

**Samaritan Cancer Center**

# 2010 Annual Report

with 2009 statistics



**Good Samaritan Hospital**  
Premier Health Partners

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*\*Dayton Physicians, LLC*

## Introduction

### **Gregory Rasp, MD**

*Radiation Oncology  
Chair, Oncology  
Committee*

### **Bobbie Martin, MS, RN**

*Director, Oncology  
Services*

We are pleased to present the Good Samaritan Hospital cancer program's annual report. All information is current for the year 2010 with the exception of the Treatment Planning Conference Report and the cancer case statistics from Oncology Data Services as those statistics cannot be finalized in real time and are reflective of the year 2009.

In 2010 we welcomed our new Medical Director for Oncology, Dr. Charles Bane. We look forward to his insights and direction for our program. Dr. Bane will also serve as the Cancer Liaison Physician.

This year the National Institute of Health, through the University of Michigan, requested our participation in a national study to look at causes of operative deaths in surgical oncology and identify resources and processes of care that account for differences in complication rates and mortality. The national results will be shared with all participating hospitals.

Cancer survivorship has been an area of focus this year. We have a committee working to identify sources of funding for a program as well as the best model for implementation. Survivorship is becoming a major focus due to the large numbers of cancer survivors expected to need ongoing services throughout the nation.

Currently in progress is the work of an oncology strategic planning group to identify oncology program goals and direction for the coming five years.

Finally, we extend our sincere appreciation to our dedicated staff and physicians who continue to actively support Good Samaritan Hospital's oncology program through their daily practice and involvement in the many initiatives we undertake. We hope to continue to provide you with the area's finest cancer care.

## Meet the New Medical Director

### **Charles L. Bane, MD**

*Hematology/Oncology,  
Cancer Physician Liaison  
Medical Director,  
Oncology Services*

It is truly an honor to serve as Medical Director of Oncology Services for Good Samaritan Hospital. I have had the pleasure of being on staff at Good Samaritan since 2000. Originally from Illinois, I received my undergraduate degree from University of Illinois followed by Medical School at Washington University in St. Louis, Missouri. My Internal Medicine Residency and Hematology/Oncology Fellowship training were completed at Wilford Hall USAF Medical Center, Lackland AFB, Texas. I completed my military service at Wright Patterson AFB in 2000 and subsequently entered private practice. I have served as President of Dayton Physicians, LLC since 2005.

As Medical Director for Oncology Services I serve as liaison between clinicians and hospital administration to insure that our efforts complement one another towards our common goal of outstanding cancer care. Major areas of emphasis at this time include supporting and expanding awareness and application of national cancer treatment guidelines through multidisciplinary conferences and the availability of patient navigators or care coordinators. Key areas for oncology program enhancement will be identified and significant quality indicators will be selected and measured.

The community and referring physicians we serve benefit from knowledge of the excellent level of cancer care available at our institution. Every effort will be made to enhance public awareness of our comprehensive and compassionate care through participation in public awareness and outreach programs.

# Oncology Program Committees

## Oncology Committee

**Gregory Rasp, MD**

*Chair, Radiation Oncologist*

**Ejaz Ahmad, MD**

*Pathologist*

**Diane Anderson, DO**

*Radiologist*

**Charles Bane, MD**

*Medical Director, Oncology Services, Cancer Liaison Physician and Medical Oncologist*

**Manibha Banerjee, MD**

*Pathologist*

**Howard Gross, MD**

*Medical Oncologist and Coordinator Oncology QI*

**John Haluschak, MD**

*Medical Oncologist*

**Shamim Jilani, MD**

*Medical Oncologist*

**Theodore Payne, MD**

*Radiologist*

**Thav Thambi-Pillai, MD**

*General Surgeon*

**Laszlo Toth, MD**

*General Surgeon*

**Jennifer Wu, MD**

*General Surgeon*

**Anita Adams, MBA, RCP**

*Vice President, Operations*

**Bobbie Martin, MS, RN**

*Director, Oncology Services*

**Connie Ickes, LISW-S**

*Social Worker*

**Brenda McCracken, BS, CTR**

*ODS Team Leader  
Quality Control Coordinator*

**Deborah Hamilton, RHIT, CTR**

*Cancer Conference Coordinator*

**Katherine Peyton, RN,**

*Research Nurse*

**Dena Helsinger, MS, RN**

*Director, Center for Outcomes, Research and Clinical Effectiveness*

## Oncology Quality Improvement Committee

**Howard Gross, MD**

*Chair, Medical Oncologist*

**Ejaz Ahmad, MD**

*Pathologist*

**Charles Bane, MD**

*Medical Director, Oncology & Medical Oncologist*

**Rebecca Paessun, MD**

*Radiation Oncologist*

**Jennifer Wu, MD**

*General Surgeon*

**Bobbie Martin, MS, RN**

*Director, Oncology Services*

**Dena Helsinger, MS, RN**

*Director, Center for Outcomes Research and Clinical Effectiveness*

## Breast Cancer Steering Committee

**Thomas Heck, MD**

*Co-Medical Director, Breast Surgeon*

**Elizabeth Maner, QA, QC**

*Coordinator, Diagnostics*

**Diane Anderson, DO**

*Co-Medical Director, Radiologist*

**Linda Trick**

*Mammographer, Breast Center*

**Shamim Jilani, MD**

*Medical Oncologist*

**Manibha Banerjee, MD**

*Pathologist*

**Rebecca Paessun, MD**

*Radiation Oncologist*

**Bobbie Martin, MS, RN**

*Director, Oncology Services*

**Ann Lensch, MS, RN, CBCN**

*Chair, Breast Care Coordinator*

**Roger Staton, CNMT, RT, (N) (MR), MBA**

*Director, Imaging*

**Mindy Shelley, BSRS, RT (R) (MR) (CT), LMT**

*Manager, Breast Center*

## Oncology Program Committees

### Lung Cancer Steering Committee

**Mohey Saleh, MD**

*Co-Director, Cardiothoracic Surgeon*

**Howard Gross, MD**

*Co-Director, Medical Oncologist*

**Aimee Russell, MD**

*Radiation Oncologist*

**Thomas Yunger, MD**

*Pulmonologist*

**Martin Ambrose, MD**

*Pulmonologist*

**Bobbie Martin, MS, RN**

*Director, Oncology Services*

**Diane Tousignant, BSN, RN,**

*Chair, Lung Cancer Coordinator*

### Palliative Care Committee

**Chirag Patel, MD**

*Board Certified in Hospice and Palliative Medicine  
Palliative Care Medical Director*

**Jules Sherman, DO, FACOI**

*Board Certified in Hospice and Palliative Medicine  
Palliative Care Medical Director*

**Betty Love, MS, RN**

*Director of Palliative Care, Critical Care and Women's Services*

**Sr. Carol Bauer, SC**

*Vice President, Mission Effectiveness*

**Sr. Rosemary Goubeaux, CPPS**

*Pastoral Care Services*

**Robyn Razor, MS, RN**

*ICU Nurse Manager*

**Charles Bane, MD**

*Medical Oncologist*

**Linda Quinlin, MS, RN,**

**ACNS-BC, NP-C**

*Palliative Care Advanced Practice Nurse*

**Craig Schneider**

*Coordinator, Spiritual Care*

**Pauline Hamblin, MS, RN**

*Nurse Manager, Medical/Surgical and In-Patient Oncology*

**Rosalee Fitzgerald, MS, RN**

*Medical/Surgical and In-Patient Oncology Unit Educator*

**Janice Moore, RN**

*Palliative Care Nurse*

**Jerry Halula, PharmD**

*Pain Management Consultant*

**Wanda Kimbrough**

*Social Worker, Integrated Care*

### Chemotherapy Safety Committee

**Dr. Howard Gross, MD**

*Out-Patient Medical Director for Oncology*

**Bobbie Martin, MS, RN**

*Chair, Director, Oncology Services*

**Sue Dodds, BSN, RN**

*Team Leader, Infusion Services*

**Alan Ayyette, RPh**

*Pharmacist*

**Mary Cubick, PharmD, CCRC**

*Pharmacist*

**Christie Gray, MS, RN**

*Medical/Surgical Nursing Director*

**Pauline Hamblin, MS, RN**

*Manager Medical/Oncology Unit*

**Rosalee Fitzgerald, MS, RN**

*Unit Educator  
Medical/Oncology Unit*

# Oncology Quality Improvement Committee

Howard Gross, MD *Chair, Medical Oncologist*

The Oncology Quality Improvement Committee is made up of representatives from all the subspecialties involved in the diagnosis and treatment of the cancer patient at Good Samaritan Hospital. It includes medical oncology, radiation oncology, surgical oncology, and pathology. The Committee met four times during the year. Individual cases with potential quality issues were reviewed for appropriateness to be sent directly to the Medical Staff Quality Committee. The Committee performed several QI studies and reviews. These included:

- **Renal Cell Cancer:** A clinical pathway was developed for Radiofrequency Ablation for Renal Cell Carcinoma. Selection criteria, treatment specifics, and follow up were defined. Urology, radiology, and medical oncology actively participated in developing this pathway.
- **Colon Cancer:** The number of lymph nodes sampled on all Colorectal cancer

cases over a twelve month time period were reviewed to see how many met a minimal goal of twelve lymph nodes removed and pathologically reviewed. Study results were sent to all surgeons who perform colorectal surgery at GSH.

- **Non Small Cell Lung Cancer:** A study was done to monitor the adequacy of mediastinal lymph node sampling in all surgical cases done for definitive treatment. A second review looked at the percentage of patients who undergo thoracotomy who have preoperative evaluation per NCCN guidelines.
- **Breast Cancer:** A study to determine what percentage of patients with early breast cancer are considered for or have axillary sentinel lymph node biopsy performed, was done. A second study to determine what percentage of early stage breast cancer patients are offered or have breast conserving surgery performed was completed as well.

## Palliative Care Program

Linda Quinlin, MS, RN, ACNS-BC, NP-C *Palliative Care*

Palliative Care is a medical specialty aimed at relieving suffering and improving the quality of life for patients with serious or life threatening conditions. Palliative care can be offered for any patient with a serious or life threatening condition any time during their illness. Palliative care services are designed to help families navigate a complex and confusing medical system while helping clinicians handle difficult communication issues and coordination of care. The palliative care team strives to maximize each patient's comfort and improve their overall quality of life.

The Palliative Care Program at Good Samaritan Hospital continues to help care for patients with complex medical illnesses and their families. Services provided include symptom management, advance directive discussion, end-of-life care, spiritual care, and discharge planning. Patients and their families receive a multidisciplinary approach to their care that includes physicians; board certified in Hospice and Palliative Medicine, an

advanced practice nurse, pastoral care, and integrated care (social worker/case manager). The goals of the palliative care team are to provide compassionate, multi-disciplinary care that addresses pain and other symptom management as well as spiritual and psycho-social concerns.

The Palliative Care Team includes:

- **Chirag Patel, MD**  
*Board Certified in Hospice and Palliative Medicine*  
*Palliative Care Medical Director*
- **Jules Sherman, DO, FACOI**  
*Board Certified in Hospice and Palliative Medicine*  
*Palliative Care Medical Director*
- **Betty Love, MS, RN**  
*Director of Palliative Care, Critical Care, and Women's Services*
- **Linda Quinlin, MS, RN, ACNS-BC, NP-C**  
*Palliative Care Advanced Practice Nurse*
- **Sr. Rosemary Goubeaux, CPPS**  
*Pastoral Care Services*

## Oncology Treatment Planning Conferences

Good Samaritan Hospital has Treatment Planning Conferences to discuss prospective treatment for newly diagnosed cancer patients or for patients with recurrence or progression of disease, and education of the medical staff. These conferences are open to any physician who needs to present a case in order to get feedback from other physicians regarding the patient's treatment. The conferences are regularly attended by

Pathology, Radiology, Radiation Oncology, Medical Oncology, and Surgery. This ensures that all aspects of a patient's treatment are addressed. In 2009, 30% of our total cancer cases were presented at multidisciplinary conferences. Breast Conference, Lung Conference, and Oncology Treatment Planning Conference which is a general conference are held weekly. Head and Neck Conference is held bi-monthly.

### 2009 Combined Cancer Conference Statistics

|                                     |     |
|-------------------------------------|-----|
| Total Number of Conferences         | 137 |
| Total Number of Cases Presented     | 374 |
| Prospective Cases                   | 373 |
| Retrospective Cases                 | 1   |
| Total Number of Didactics Presented | 2   |
| Average Attendance                  | 21  |
| Average Medical Staff Attendance    | 12  |

### 2009 Head & Neck Cancer Conference Statistics Director: Dr. Greg Rasp

|                                     |    |
|-------------------------------------|----|
| Total Number of Conferences         | 3  |
| Total Number of Cases Presented     | 11 |
| Prospective Cases                   | 11 |
| Retrospective Cases                 | 0  |
| Total Number of Didactics Presented | 0  |
| Average Attendance                  | 16 |
| Average Medical Staff Attendance    | 9  |

### 2009 Breast Cancer Conference Statistics Director: Dr. Thomas Heck

|                                     |     |
|-------------------------------------|-----|
| Total Number of Conferences         | 44  |
| Total Number of Cases Presented     | 155 |
| Prospective Cases                   | 155 |
| Retrospective Cases                 | 0   |
| Total Number of Didactics Presented | 1   |
| Average Attendance                  | 20  |
| Average Medical Staff Attendance    | 9   |

## 2009 Lung Cancer Conference Statistics

Co-Directors: Dr. Howard Gross, Dr. Mohey Saleh

|                                     |     |
|-------------------------------------|-----|
| Total Number of Conferences         | 46  |
| Total Number of Cases Presented     | 122 |
| Prospective Cases                   | 121 |
| Retrospective Cases                 | 1   |
| Total Number of Didactics Presented | 0   |
| Average Attendance                  | 21  |
| Average Medical Staff Attendance    | 14  |

## 2009 General Oncology Treatment Planning Conference Statistics

|                                     |    |
|-------------------------------------|----|
| Total Number of Conferences         | 44 |
| Total Number of Cases Presented     | 86 |
| Prospective Cases                   | 86 |
| Retrospective Cases                 | 0  |
| Total Number of Didactics Presented | 1  |
| Average Attendance                  | 26 |
| Average Medical Staff Attendance    | 16 |

## 2009 Didactic Lectures

### March 19, 2009

#### Updates on Post Mastectomy Reconstruction

*Dr. R. Michael Johnson  
Good Samaritan Hospital  
Breast Cancer Conference*

### November 20, 2009

#### Prostate Cancer

*Dr. Greg Rasp  
Good Samaritan Hospital  
Oncology Treatment Planning Conference*

# Oncology Data Services

**Brenda McCracken, BS, CTR** *Team Leader, Oncology Data Services*

The primary function of Oncology Data Services is to collect and disseminate data as it relates to oncology in order to reflect a complete and accurate picture of each individual oncology patient's disease. ODS obtains history from patients from a time prior to their diagnosis and follows them until the time of their death. Trends in data are reviewed and further studies are built on the trends seen from registry data. The Oncology Quality Improvement Committee requests and relies on this data to evaluate quality of outcomes and identify opportunities for improvement.

Physician members of the Oncology Committee oversee the work of Oncology Data Services to assure that complete and accurate data is collected. NCCN guidelines are used to determine accuracy and appropriate treatment. Through our Oncology QI Committee, physicians review over 10% of our top sites for compliance with these guidelines. If deviations from the guidelines are found, the case is discussed with the Oncology QI committee to determine appropriateness of the deviation.

In addition to reporting data within GSH to physicians and administration, data is sent to the National Cancer Data Bank (NCDB) and to the Ohio Cancer Incidence Surveillance System (OCISS). Reporting to OCISS is mandatory by state law. Reporting to NCDB is required for accreditation of the oncology program.

Essential components and functions of the cancer registry include:

- Determining case eligibility. Reference is made to the current Commission on Cancer data standards and coding instructions for specific requirements of cases to be included in the registry.
- Ensuring complete case finding, using multiple sources to identify all eligible cases that are to be included in the cancer registry
- Holding cases in suspense until time of complete abstracting.
- Abstracting cases by collecting all required data elements for each case of cancer.
- Maintaining quality of data collected which requires physicians reviewing 10% of cases abstracted
- Performing on-going follow-up. This includes data on date of first recurrence, cancer status, date of last contact or date of death.
- Reporting of data to various entities such as Oncology Committee, Hospital Administration, National Cancer Data Base, and Ohio Cancer Incidence Surveillance System.
- Coordinating the Treatment Planning Conferences for physicians and other involved oncology staff.

The Oncology Data Services team is in a unique position to see the whole picture of the cancer patient and contributes important data useful for our physicians as they continue to pursue oncology quality.

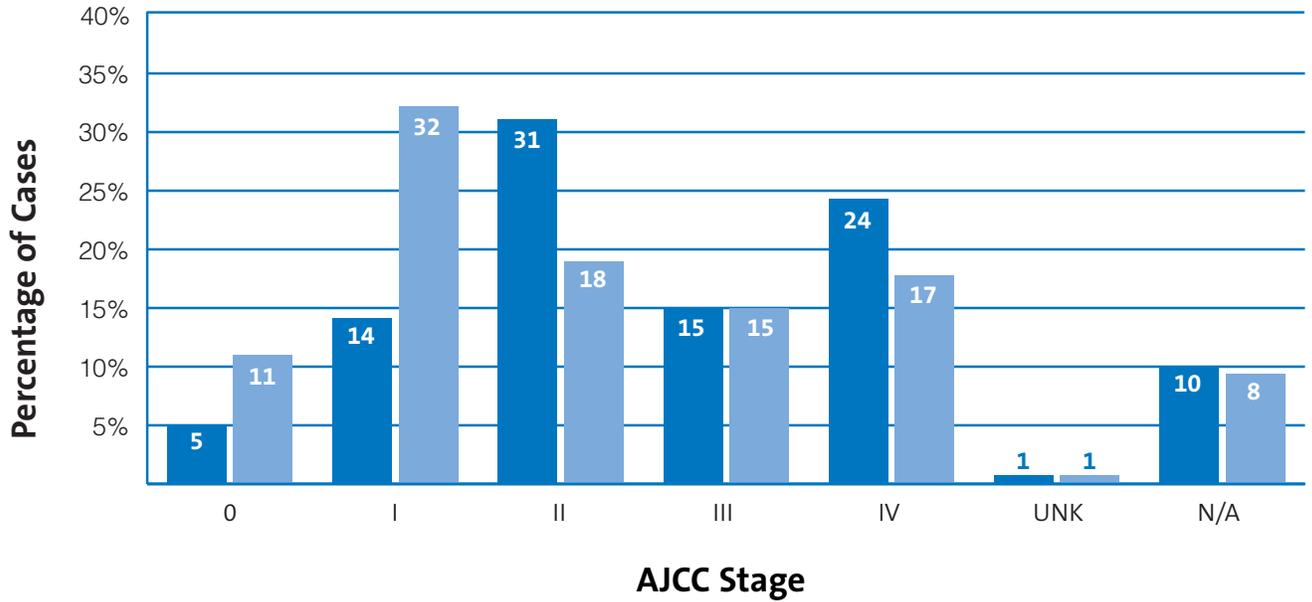
## Good Samaritan Hospital Site Summary Table

| Primary Site                               | Total Cases        | Sex        |            | Class of Case |              | Status     |            | Stage Distribution/Analytic Only |           |           |           |            |          |          |
|--|--------------------|------------|------------|---------------|--------------|------------|------------|----------------------------------|-----------|-----------|-----------|------------|----------|----------|
|  |                    | Male       | Female     | Analytic      | Non Analytic | Alive      | Exp        | 0                                | I         | II        | III       | IV         | N/A      | Unk      |
| <b>Oral Cavity &amp; Pharynx</b>           | <b>37 (2.7%)</b>   | <b>25</b>  | <b>12</b>  | <b>31</b>     | <b>6</b>     | <b>30</b>  | <b>7</b>   | <b>0</b>                         | <b>8</b>  | <b>4</b>  | <b>6</b>  | <b>12</b>  | <b>0</b> | <b>1</b> |
| Tongue                                     | 8 (0.6%)           | 3          | 5          | 6             | 2            | 6          | 2          | 0                                | 2         | 3         | 0         | 1          | 0        | 0        |
| Salivary Glands                            | 7 (0.5%)           | 5          | 2          | 7             | 0            | 5          | 2          | 0                                | 1         | 0         | 2         | 3          | 0        | 1        |
| Floor of Mouth                             | 2 (0.1%)           | 2          | 0          | 2             | 0            | 2          | 0          | 0                                | 2         | 0         | 0         | 0          | 0        | 0        |
| Gum & Other Mouth                          | 3 (0.2%)           | 1          | 2          | 2             | 1            | 3          | 0          | 0                                | 1         | 0         | 0         | 1          | 0        | 0        |
| Tonsil                                     | 8 (0.6%)           | 6          | 2          | 8             | 0            | 6          | 2          | 0                                | 1         | 1         | 1         | 5          | 0        | 0        |
| Oropharynx                                 | 5 (0.4%)           | 5          | 0          | 3             | 2            | 4          | 1          | 0                                | 0         | 0         | 2         | 1          | 0        | 0        |
| Hypopharynx                                | 3 (0.2%)           | 2          | 1          | 3             | 0            | 3          | 0          | 0                                | 1         | 0         | 1         | 1          | 0        | 0        |
| Other Oral Cavity & Pharynx                | 1 (0.1%)           | 1          | 0          | 0             | 1            | 1          | 0          | 0                                | 0         | 0         | 0         | 0          | 0        | 0        |
| <b>Digestive System</b>                    | <b>217 (15.6%)</b> | <b>110</b> | <b>107</b> | <b>197</b>    | <b>20</b>    | <b>119</b> | <b>98</b>  | <b>3</b>                         | <b>33</b> | <b>43</b> | <b>42</b> | <b>68</b>  | <b>5</b> | <b>3</b> |
| Esophagus                                  | 17 (1.2%)          | 11         | 6          | 16            | 1            | 8          | 9          | 0                                | 3         | 4         | 2         | 7          | 0        | 0        |
| Stomach                                    | 15 (1.1%)          | 9          | 6          | 12            | 3            | 6          | 9          | 0                                | 3         | 3         | 2         | 4          | 0        | 0        |
| Small Intestine                            | 4 (0.3%)           | 2          | 2          | 4             | 0            | 4          | 0          | 0                                | 1         | 0         | 2         | 1          | 0        | 0        |
| Colon Excluding Rectum                     | 84 (6.1%)          | 41         | 43         | 80            | 4            | 59         | 25         | 3                                | 14        | 17        | 21        | 24         | 1        | 0        |
| Cecum                                      | 21                 | 7          | 14         | 20            | 1            | 13         | 8          | 1                                | 5         | 3         | 5         | 6          | 0        | 0        |
| Appendix                                   | 3                  | 1          | 2          | 3             | 0            | 3          | 0          | 0                                | 0         | 2         | 1         | 0          | 0        | 0        |
| Ascending Colon                            | 21                 | 9          | 12         | 19            | 2            | 20         | 1          | 0                                | 8         | 4         | 4         | 3          | 0        | 0        |
| Hepatic Flexure                            | 3                  | 2          | 1          | 3             | 0            | 2          | 1          | 0                                | 0         | 2         | 0         | 1          | 0        | 0        |
| Transverse Colon                           | 5                  | 1          | 4          | 5             | 0            | 2          | 3          | 1                                | 0         | 2         | 0         | 1          | 1        | 0        |
| Splenic Flexure                            | 1                  | 1          | 0          | 1             | 0            | 1          | 0          | 0                                | 0         | 0         | 0         | 1          | 0        | 0        |
| Descending Colon                           | 3                  | 2          | 1          | 3             | 0            | 2          | 1          | 0                                | 0         | 0         | 2         | 1          | 0        | 0        |
| Sigmoid Colon                              | 22                 | 15         | 7          | 21            | 1            | 13         | 9          | 1                                | 1         | 2         | 7         | 10         | 0        | 0        |
| Large Intestine, NOS                       | 5                  | 3          | 2          | 5             | 0            | 3          | 2          | 0                                | 0         | 2         | 2         | 1          | 0        | 0        |
| Rectum & Rectosigmoid                      | 32 (2.3%)          | 13         | 19         | 27            | 5            | 24         | 8          | 0                                | 5         | 3         | 8         | 8          | 2        | 1        |
| Rectosigmoid Junction                      | 9                  | 2          | 7          | 9             | 0            | 6          | 3          | 0                                | 3         | 0         | 3         | 2          | 0        | 1        |
| Rectum                                     | 23                 | 11         | 12         | 18            | 5            | 18         | 5          | 0                                | 2         | 3         | 5         | 6          | 2        | 0        |
| Anus, Anal Canal & Anorectum               | 9 (0.6%)           | 2          | 7          | 7             | 2            | 4          | 5          | 0                                | 1         | 3         | 1         | 1          | 1        | 0        |
| Liver & Intrahepatic Bile Duct             | 11 (0.8%)          | 8          | 3          | 10            | 1            | 3          | 8          | 0                                | 2         | 1         | 3         | 2          | 0        | 2        |
| Liver                                      | 10                 | 7          | 3          | 10            | 0            | 3          | 7          | 0                                | 2         | 1         | 3         | 2          | 0        | 2        |
| Intrahepatic Bile Duct                     | 1                  | 1          | 0          | 0             | 1            | 0          | 1          | 0                                | 0         | 0         | 0         | 0          | 0        | 0        |
| Gallbladder                                | 4 (0.3%)           | 0          | 4          | 3             | 1            | 1          | 3          | 0                                | 2         | 0         | 0         | 1          | 0        | 0        |
| Other Biliary                              | 1 (0.1%)           | 1          | 0          | 1             | 0            | 1          | 0          | 0                                | 0         | 0         | 0         | 1          | 0        | 0        |
| Pancreas                                   | 34 (2.5%)          | 19         | 15         | 32            | 2            | 4          | 30         | 0                                | 1         | 11        | 2         | 18         | 0        | 0        |
| Retroperitoneum                            | 4 (0.3%)           | 2          | 2          | 3             | 1            | 3          | 1          | 0                                | 1         | 1         | 1         | 0          | 0        | 0        |
| Peritoneum, Omentum & Mesentery            | 1 (0.1%)           | 1          | 0          | 1             | 0            | 1          | 0          | 0                                | 0         | 0         | 0         | 1          | 0        | 0        |
| Other Digestive Organs                     | 1 (0.1%)           | 1          | 0          | 1             | 0            | 1          | 0          | 0                                | 0         | 0         | 0         | 0          | 1        | 0        |
| <b>Respiratory System</b>                  | <b>291 (21.0%)</b> | <b>159</b> | <b>132</b> | <b>266</b>    | <b>25</b>    | <b>124</b> | <b>167</b> | <b>2</b>                         | <b>60</b> | <b>12</b> | <b>75</b> | <b>115</b> | <b>1</b> | <b>1</b> |
| Larynx                                     | 11 (0.8%)          | 9          | 2          | 11            | 0            | 8          | 3          | 0                                | 6         | 1         | 1         | 3          | 0        | 0        |
| Lung & Bronchus                            | 280 (20.2%)        | 150        | 130        | 255           | 25           | 116        | 164        | 2                                | 54        | 11        | 74        | 112        | 1        | 1        |
| <b>Bones &amp; Joints</b>                  | <b>(0.1%)</b>      | <b>2</b>   | <b>0</b>   | <b>2</b>      | <b>0</b>     | <b>1</b>   | <b>1</b>   | <b>0</b>                         | <b>1</b>  | <b>0</b>  | <b>0</b>  | <b>0</b>   | <b>0</b> | <b>1</b> |
| Bones & Joints                             | 2 (0.1%)           | 2          | 0          | 2             | 0            | 1          | 1          | 0                                | 1         | 0         | 0         | 0          | 0        | 1        |
| <b>Soft Tissue</b>                         | <b>9 (0.6%)</b>    | <b>5</b>   | <b>4</b>   | <b>6</b>      | <b>3</b>     | <b>7</b>   | <b>2</b>   | <b>0</b>                         | <b>2</b>  | <b>0</b>  | <b>0</b>  | <b>1</b>   | <b>0</b> | <b>3</b> |
| Soft Tissue (including Heart)              | 9 (0.6%)           | 5          | 4          | 6             | 3            | 7          | 2          | 0                                | 2         | 0         | 0         | 1          | 0        | 3        |
| <b>Skin Excluding Basal &amp; Squamous</b> | <b>11 (0.8%)</b>   | <b>5</b>   | <b>6</b>   | <b>6</b>      | <b>5</b>     | <b>9</b>   | <b>2</b>   | <b>1</b>                         | <b>1</b>  | <b>3</b>  | <b>0</b>  | <b>1</b>   | <b>0</b> |          |
| Melanoma – Skin                            | 9 (0.6%)           | 4          | 5          | 5             | 4            | 8          | 1          | 1                                | 1         | 2         | 0         | 1          | 0        | 0        |
| Other Non-Epithelial Skin                  | 2 (0.1%)           | 1          | 1          | 1             | 1            | 1          | 1          | 0                                | 0         | 1         | 0         | 0          | 0        | 0        |
| <b>Basal &amp; Squamous Skin</b>           | <b>1 (0.1%)</b>    | <b>1</b>   | <b>0</b>   | <b>0</b>      | <b>1</b>     | <b>1</b>   | <b>0</b>   | <b>0</b>                         | <b>0</b>  | <b>0</b>  | <b>0</b>  | <b>0</b>   | <b>0</b> | <b>0</b> |
| Basal/Squamous cell carcinomas of Skin     | 1 (0.1%)           | 1          | 0          | 0             | 1            | 1          | 0          | 0                                | 0         | 0         | 0         | 0          | 0        | 0        |

# Good Samaritan Hospital Site Summary Table

| Primary Site                            | Total Cases        | Sex        |            | Class of Case |              | Status     |            | Stage Distribution/Analytic Only |            |            |            |            |            |           |
|---|--------------------|------------|------------|---------------|--------------|------------|------------|----------------------------------|------------|------------|------------|------------|------------|-----------|
|   |                    | Male       | Female     | Analytic      | Non Analytic | Alive      | Exp        | 0                                | I          | II         | III        | IV         | N/A        | Unk       |
| <b>Breast</b>                           | <b>276 (19.9%)</b> | <b>2</b>   | <b>274</b> | <b>261</b>    | <b>15</b>    | <b>263</b> | <b>13</b>  | <b>50</b>                        | <b>102</b> | <b>66</b>  | <b>31</b>  | <b>11</b>  | <b>0</b>   | <b>1</b>  |
| Breast                                  | 276 (19.9%)        | 2          | 274        | 261           | 15           | 263        | 13         | 50                               | 102        | 66         | 31         | 11         | 0          | 1         |
| <b>Female Genital System</b>            | <b>55 (4.0%)</b>   | <b>0</b>   | <b>55</b>  | <b>50</b>     | <b>5</b>     | <b>42</b>  | <b>13</b>  | <b>1</b>                         | <b>24</b>  | <b>6</b>   | <b>9</b>   | <b>5</b>   | <b>3</b>   | <b>2</b>  |
| Cervix Uteri                            | 6 (0.4%)           | 0          | 6          | 5             | 1            | 2          | 4          | 0                                | 2          | 1          | 1          | 1          | 0          | 0         |
| Corpus & Uterus, NOS                    | 37 (2.7%)          | 0          | 37         | 36            | 1            | 31         | 6          | 0                                | 20         | 4          | 5          | 2          | 3          | 2         |
| Corpus Uteri                            | 35                 | 0          | 35         | 34            | 1            | 30         | 5          | 0                                | 20         | 4          | 4          | 2          | 2          | 2         |
| Uterus, NOS                             | 2                  | 0          | 2          | 2             | 0            | 1          | 1          | 0                                | 0          | 0          | 1          | 0          | 1          | 0         |
| Ovary                                   | 8 (0.6%)           | 0          | 8          | 6             | 2            | 6          | 2          | 0                                | 2          | 1          | 1          | 2          | 0          | 0         |
| Vulva                                   | 4 (0.3%)           | 0          | 4          | 3             | 1            | 3          | 1          | 1                                | 0          | 0          | 2          | 0          | 0          | 0         |
| <b>Male Genital System</b>              | <b>191 (13.8%)</b> | <b>191</b> | <b>0</b>   | <b>162</b>    | <b>29</b>    | <b>176</b> | <b>15</b>  | <b>0</b>                         | <b>5</b>   | <b>139</b> | <b>6</b>   | <b>9</b>   | <b>2</b>   | <b>1</b>  |
| Prostate                                | 183 (13.2%)        | 183        | 0          | 154           | 29           | 168        | 15         | 0                                | 0          | 139        | 6          | 9          | 0          | 0         |
| Testis                                  | 6 (0.4%)           | 6          | 0          | 6             | 0            | 6          | 0          | 0                                | 5          | 0          | 0          | 0          | 0          | 1         |
| Other Male Genital Organs               | 2 (0.1%)           | 2          | 0          | 2             | 0            | 2          | 0          | 0                                | 0          | 0          | 0          | 0          | 2          | 0         |
| <b>Urinary System</b>                   | <b>105 (7.6%)</b>  | <b>72</b>  | <b>33</b>  | <b>90</b>     | <b>15</b>    | <b>81</b>  | <b>24</b>  | <b>32</b>                        | <b>32</b>  | <b>7</b>   | <b>5</b>   | <b>11</b>  | <b>2</b>   | <b>1</b>  |
| Urinary Bladder                         | 64 (4.6%)          | 46         | 18         | 52            | 12           | 44         | 20         | 32                               | 12         | 2          | 1          | 4          | 0          | 1         |
| Kidney & Renal Pelvis                   | 38 (2.7%)          | 25         | 13         | 35            | 3            | 35         | 3          | 0                                | 19         | 5          | 4          | 7          | 0          | 0         |
| Other Urinary Organs                    | 3 (0.2%)           | 1          | 2          | 3             | 0            | 2          | 1          | 0                                | 1          | 0          | 0          | 0          | 2          | 0         |
| <b>Brain &amp; Other Nervous System</b> | <b>25 (1.8%)</b>   | <b>14</b>  | <b>11</b>  | <b>19</b>     | <b>6</b>     | <b>21</b>  | <b>4</b>   | <b>0</b>                         | <b>0</b>   | <b>0</b>   | <b>0</b>   | <b>0</b>   | <b>19</b>  | <b>0</b>  |
| Brain                                   | 13 (0.9%)          | 10         | 3          | 9             | 4            | 10         | 3          | 0                                | 0          | 0          | 0          | 0          | 9          | 0         |
| Cranial Nerves Other Nervous System     | 12 (0.9%)          | 4          | 8          | 10            | 2            | 11         | 1          | 0                                | 0          | 0          | 0          | 0          | 10         | 0         |
| <b>Endocrine System</b>                 | <b>20 (1.4%)</b>   | <b>8</b>   | <b>12</b>  | <b>17</b>     | <b>3</b>     | <b>16</b>  | <b>4</b>   | <b>0</b>                         | <b>8</b>   | <b>1</b>   | <b>1</b>   | <b>1</b>   | <b>6</b>   | <b>0</b>  |
| Thyroid                                 | 11 (0.8%)          | 3          | 8          | 11            | 0            | 9          | 2          | 0                                | 8          | 1          | 1          | 1          | 0          | 0         |
| Other Endocrine including Thymus        | 9 (0.6%)           | 5          | 4          | 6             | 3            | 7          | 2          | 0                                | 0          | 0          | 0          | 0          | 6          | 0         |
| <b>Lymphoma</b>                         | <b>57 (4.1%)</b>   | <b>29</b>  | <b>28</b>  | <b>50</b>     | <b>7</b>     | <b>40</b>  | <b>17</b>  | <b>0</b>                         | <b>15</b>  | <b>10</b>  | <b>8</b>   | <b>17</b>  | <b>0</b>   | <b>0</b>  |
| Hodgkin Lymphoma                        | 10 (0.7%)          | 5          | 5          | 10            | 0            | 9          | 1          | 0                                | 4          | 4          | 2          | 0          | 0          | 0         |
| Non-Hodgkin Lymphoma                    | 47 (3.4%)          | 24         | 23         | 40            | 7            | 31         | 16         | 0                                | 11         | 6          | 6          | 17         | 0          | 0         |
| NHL – Nodal                             | 34                 | 18         | 16         | 29            | 5            | 21         | 13         | 0                                | 5          | 5          | 6          | 13         | 0          | 0         |
| NHL – Extranodal                        | 13                 | 6          | 7          | 11            | 2            | 10         | 3          | 0                                | 6          | 1          | 0          | 4          | 0          | 0         |
| <b>Myeloma</b>                          | <b>18 (1.3%)</b>   | <b>10</b>  | <b>8</b>   | <b>16</b>     | <b>2</b>     | <b>15</b>  | <b>3</b>   | <b>0</b>                         | <b>0</b>   | <b>0</b>   | <b>0</b>   | <b>0</b>   | <b>16</b>  | <b>0</b>  |
| <b>Leukemia</b>                         | <b>20 (1.4%)</b>   | <b>8</b>   | <b>12</b>  | <b>14</b>     | <b>6</b>     | <b>9</b>   | <b>11</b>  | <b>0</b>                         | <b>0</b>   | <b>0</b>   | <b>0</b>   | <b>0</b>   | <b>14</b>  | <b>0</b>  |
| Lymphocytic Leukemia                    | 9 (0.6%)           | 4          | 5          | 6             | 3            | 5          | 4          | 0                                | 0          | 0          | 0          | 0          | 6          | 0         |
| Acute Lymphocytic Leukemia              | 1                  | 1          | 0          | 1             | 0            | 0          | 1          | 0                                | 0          | 0          | 0          | 0          | 1          | 0         |
| Chronic Lymphocytic Leukemia            | 8                  | 3          | 5          | 5             | 3            | 5          | 3          | 0                                | 0          | 0          | 0          | 0          | 5          | 0         |
| Myeloid & Monocytic Leukemia            | 8 (0.6%)           | 3          | 5          | 7             | 1            | 2          | 6          | 0                                | 0          | 0          | 0          | 0          | 7          | 0         |
| Acute Myeloid Leukemia                  | 5                  | 2          | 3          | 4             | 1            | 1          | 4          | 0                                | 0          | 0          | 0          | 0          | 4          | 0         |
| Chronic Myeloid Leukemia                | 1                  | 1          | 0          | 1             | 0            | 1          | 0          | 0                                | 0          | 0          | 0          | 0          | 1          | 0         |
| Other Myeloid/ Monocytic Leukemia       | 2                  | 0          | 2          | 2             | 0            | 0          | 2          | 0                                | 0          | 0          | 0          | 0          | 2          | 0         |
| Other Leukemia                          | 3 (0.2%)           | 1          | 2          | 1             | 2            | 2          | 1          | 0                                | 0          | 0          | 0          | 0          | 1          | 0         |
| Other Acute Leukemia                    | 1                  | 0          | 1          | 0             | 1            | 1          | 0          | 0                                | 0          | 0          | 0          | 0          | 0          | 0         |
| Aleukemic, Subleukemic & NOS            | 2                  | 1          | 1          | 1             | 1            | 1          | 1          | 0                                | 0          | 0          | 0          | 0          | 1          | 0         |
| <b>Mesothelioma</b>                     | <b>2 (0.1%)</b>    | <b>1</b>   | <b>1</b>   | <b>2</b>      | <b>0</b>     | <b>1</b>   | <b>1</b>   | <b>0</b>                         | <b>0</b>   | <b>1</b>   | <b>1</b>   | <b>0</b>   | <b>0</b>   | <b>0</b>  |
| <b>Miscellaneous</b>                    | <b>50 (3.6%)</b>   | <b>26</b>  | <b>24</b>  | <b>44</b>     | <b>6</b>     | <b>22</b>  | <b>28</b>  | <b>0</b>                         | <b>0</b>   | <b>0</b>   | <b>0</b>   | <b>0</b>   | <b>44</b>  | <b>0</b>  |
| <b>Total</b>                            | <b>1,387</b>       | <b>668</b> | <b>719</b> | <b>1,233</b>  | <b>154</b>   | <b>977</b> | <b>410</b> | <b>89</b>                        | <b>291</b> | <b>292</b> | <b>184</b> | <b>251</b> | <b>112</b> | <b>14</b> |

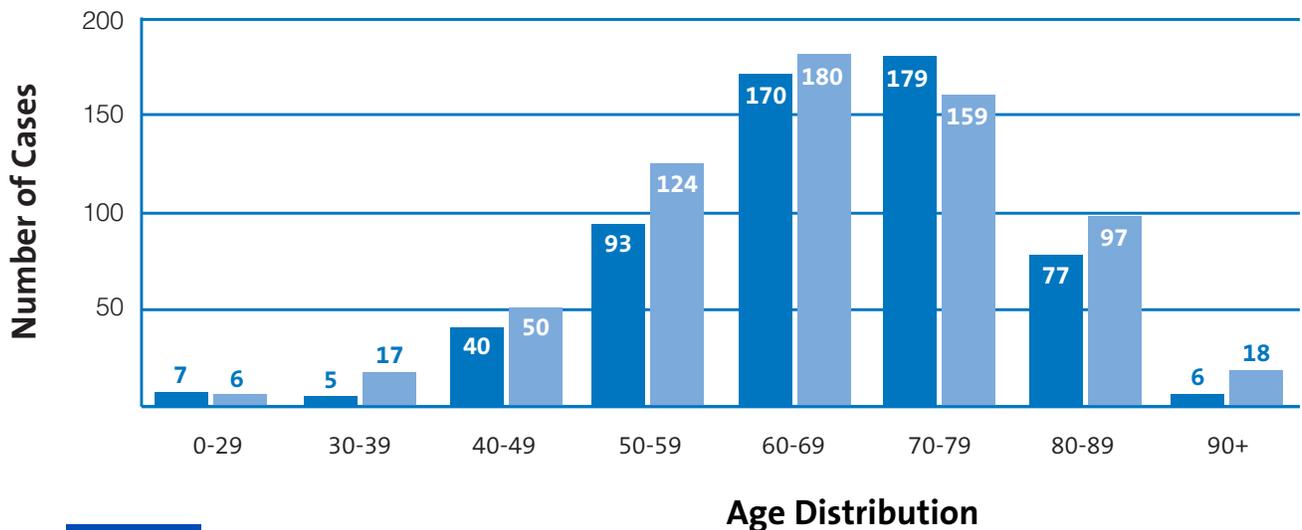
## Male vs Female by AJCC Stage 2009 Analytic Classes



Male  
Female

Early diagnosis is important at GSH. Routine screenings are provided for Breast, Skin and other cancers. Early detection means a better prognosis for patients. Over half our patients are diagnosed at stage II or lower. Most prostate cancers are diagnosed at stage II which accounts for the high rate for stage II in males.

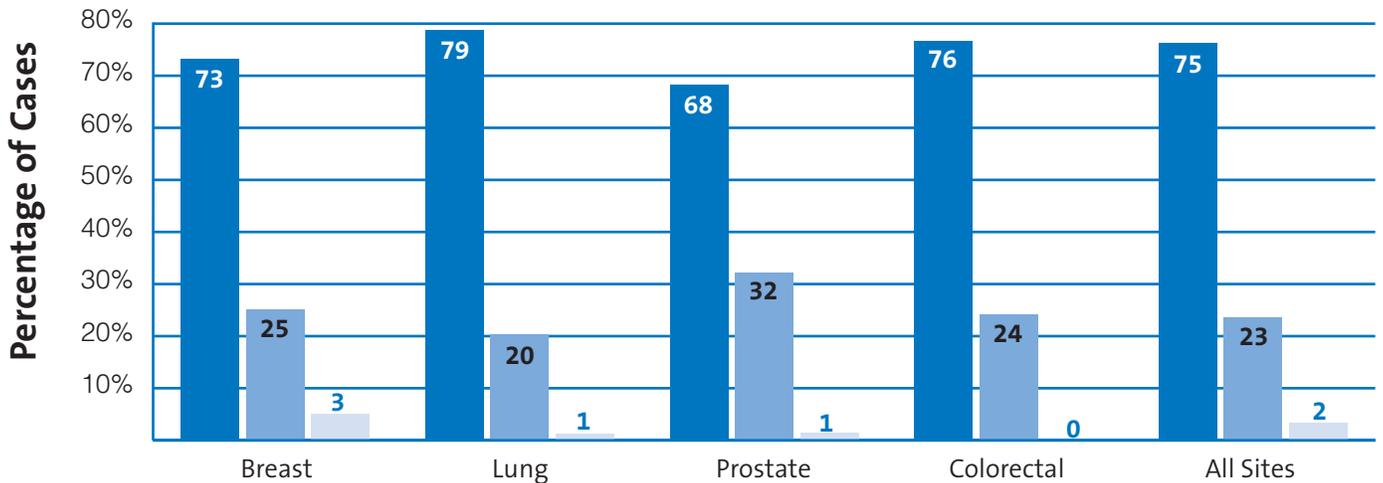
## Male vs Female by Age at Diagnosis 2009 Analytic Cases



Male  
Female

This graph represents the age and gender at diagnosis. As expected, the incidence of cancer increases with age as reflected in ages 60-79

## 2009 Race Distribution by Selected Sites and All Sites

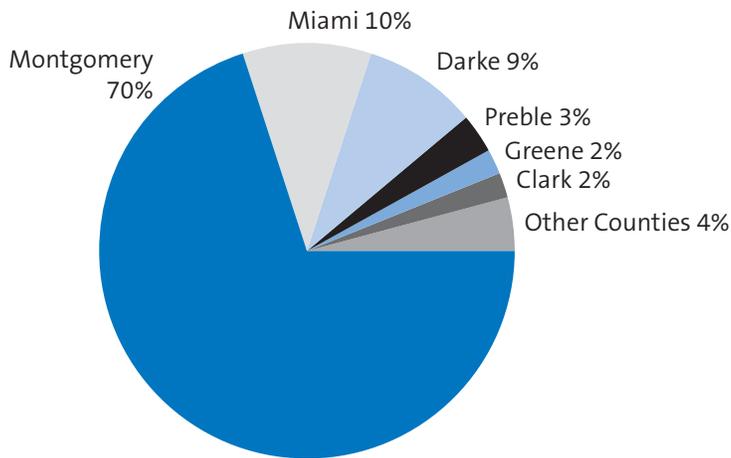


| Race             | Breast | Lung | Prostate | Colorectal | All Sites |
|------------------|--------|------|----------|------------|-----------|
| Caucasian        | 77%    | 72%  | 64%      | 68%        | 72%       |
| African-American | 18%    | 25%  | 30%      | 22%        | 23%       |
| Other            | 5%     | 4%   | 6%       | 10%        | 5%        |

### Selected Sites

This graph shows the breakdown of selected sites by race. Caucasians account for about 72% of cancer cases at GSH.

## Good Samaritan Hospital Cases by County 2009



### Follow-Up Statistics Oncology Data Services

|                      | 10 year f/u rate | %    | 5 year f/u rate | %    |
|----------------------|------------------|------|-----------------|------|
| Total Cases*         | 17,222           |      | 5,973           |      |
| Total Analytic Cases | 16,101           | 100% | 5,593           | 100% |
| Expired              | 8,837            | 55%  | 2,042           | 37%  |
| Living               | 7,264            | 45%  | 3,551           | 63%  |
| Lost to Follow-up    | 2,458            | 15%  | 440             | 8%   |
| Follow-up Rate       |                  | 85%  |                 | 92%  |
| Target               |                  | 80%  |                 | 90%  |

\*Reference Date: 1992

## Prostate Cancer: Site Specific Study with Analysis of Five Year Survival Data

**Greg Rasp, MD** *Radiation Oncologist*

Prostate cancer is an extremely common cancer. It affects approximately 157 men per 100,000 in the United States. Its incidence amongst African-Americans is about 50% higher than in Caucasians. It is less commonly seen in Asians and Native Americans. The volume of prostate cancer cases seen at Good Samaritan Hospital varies from year to year but has more than doubled in the last decade.

Prostate cancer originates in the prostate gland. This is a walnut -sized gland found only in men. It is found at the lower border of the urinary bladder and just in front of the rectum. The gland's purpose is to create a significant portion of the ejaculate.

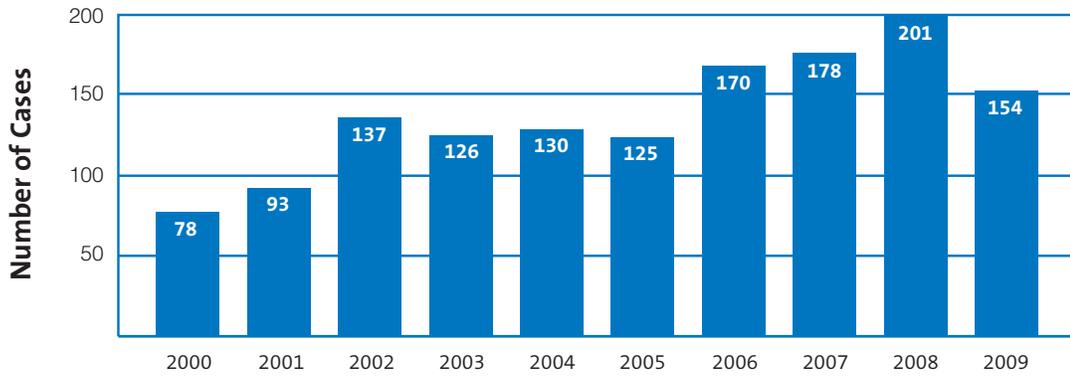
Most prostate cancers are now discovered after the prostate specific antigen (PSA) is found to be either increasing or to have an elevated level. Alternatively, the gland can be found to be abnormal on digital rectal examination (DRE). The combination of these technologies is highly effective in finding prostate cancer in early stages. While controversial, PSA screening clearly finds cancers in earlier stages. While it often finds cancers that do not need treatment, it is undeniable that the death rate from prostate cancer in the United States has been declining. This coincided with an eight to ten year lag period after the introduction of PSA screening. This is precisely what one would expect of a successful screening program.

Patients diagnosed with early stage prostate cancer have a variety of bewildering options facing them. Everything

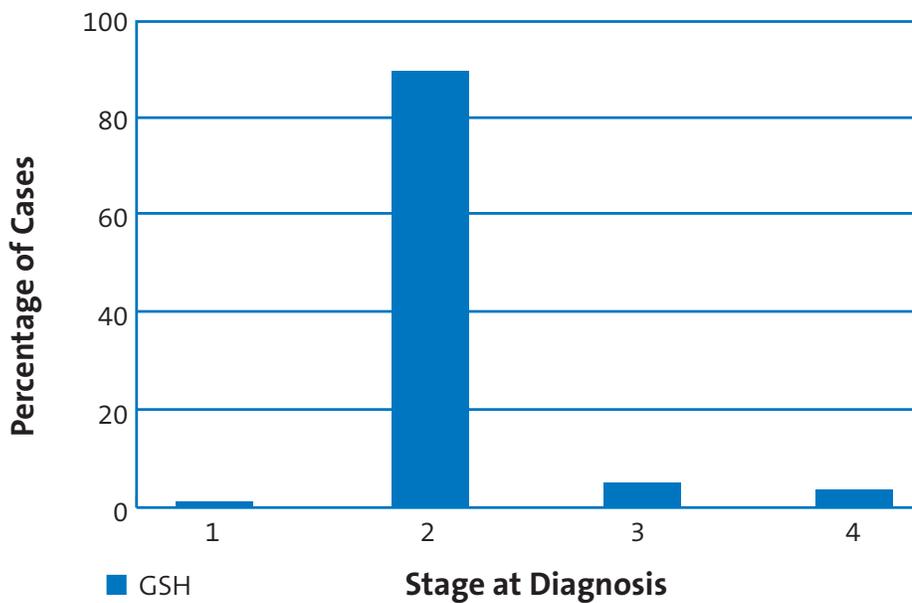
from watchful waiting, hormonal therapy, various types of radiation therapy, and differing forms of surgery, to more esoteric treatments such as light proton beam therapy, cryotherapy, and high intensity focused ultrasound. In general however, these can broadly be reduced into two primary treatment modalities: surgical versus radiation therapy. With Stage II disease, the cure rates for these two treatment modalities are extremely comparable. The primary difference between these two modalities is the extent to which staging is accomplished. Additionally radiation therapy patients are often an older patient population. This and the slow rate of growth of prostate cancer makes five year overall survival difficult to interpret between institutions. Most patients dying within five years will have done so because of co-morbidities if they are in Stage I – III. Surgical staging is more complete and often determines a higher Gleason's score than anticipated by transrectal needle biopsies. Additionally, poor prognostic factors like lymph node invasion can be noted. In a series of patients receiving radiation therapy, one would expect stage migration to somewhat limit treatment results.

We have analyzed our five year overall survival rates. They are comparable with NCDB (National Cancer Data Bank) data. Five year survival is not a great measure though for prostate cancer patients, as patients in Stage I through III do not succumb to the disease in that time interval. For that reason, five year overall survival tends to be more a function of co-morbidities and age than effectiveness of therapy.

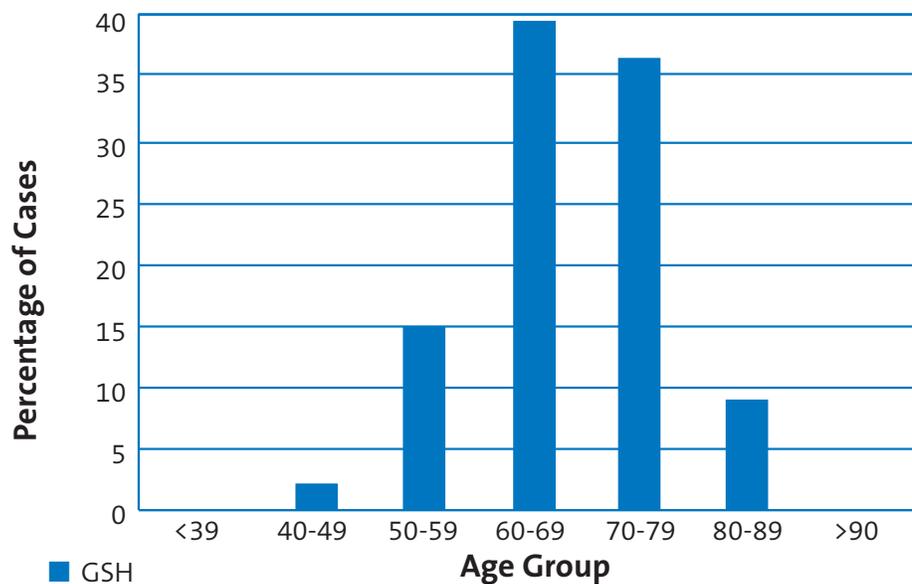
**Figure 1: Prostate Cancer Cases Per Year**



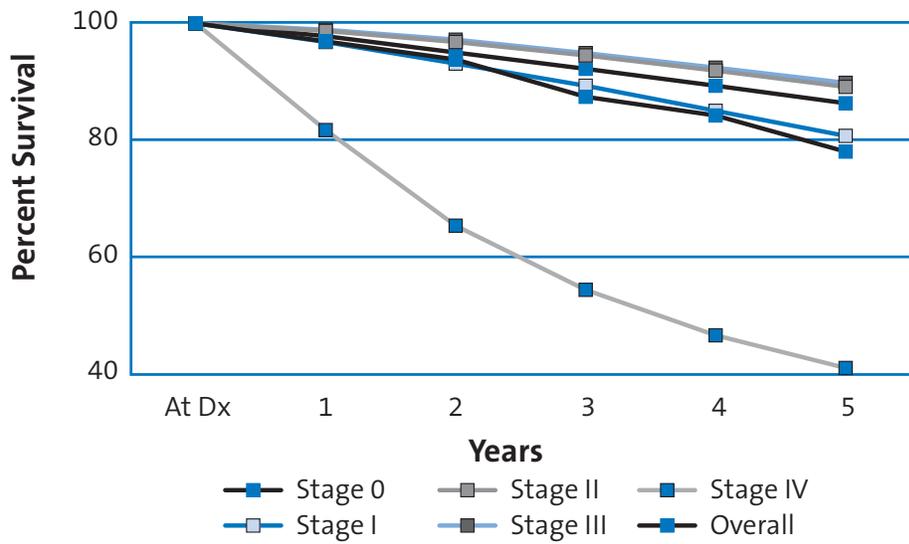
**Figure 2: Prostate Cancer Cases by Stage at Diagnosis**



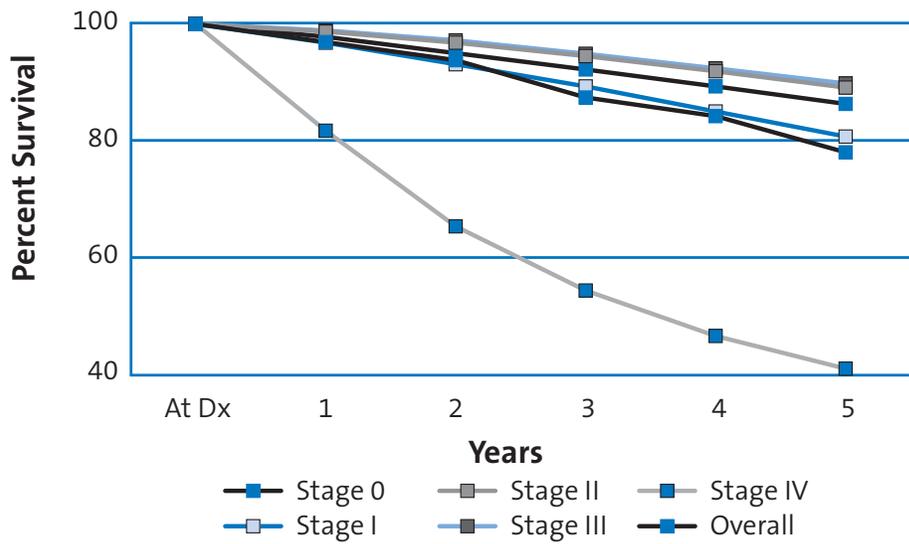
**Figure 3: Prostate Cancer by Age at diagnosis**



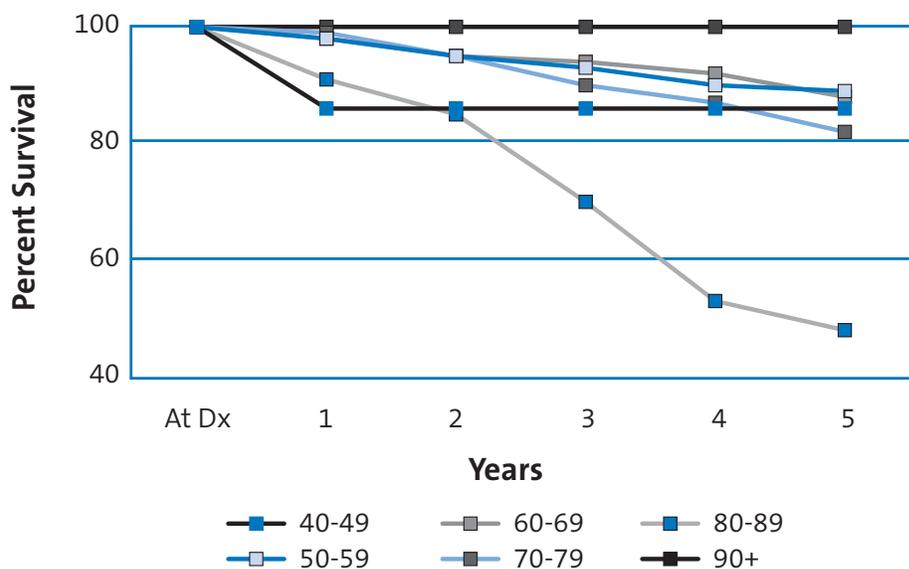
**Figure 4: NCDB Five year survival Prostate Cancer 1998-2002**



**Figure 5: Five year survival by stage**



**Figure 5: Five year survival by age**



# Pathology of Prostate Cancer

Carolyn Misick, MD *Pathologist*

Prostate cancer is the second most common cancer in men. Though the incidence of prostate cancer is high there is still little known about the causes of prostate carcinoma. Pathologic diagnosis relies primarily on histologic features; however, there are a few immunohistochemical markers that are helpful.

High grade prostatic intraepithelial neoplasia is the only atypical epithelial lesion of the prostate to be shown to be a pre-malignant lesion with clinical significance. Normal prostate tissue is composed of ductal and acinar structures, both of which have a dual lining of basal and secretory cells. The diagnosis of prostatic intraepithelial neoplasia (PIN), requires a combination of architectural and cytologic features. High grade PIN has more cell crowding, stratification and nuclear enlargement than benign acini. PIN has a variety of morphologic patterns from flat epithelium to complex cribriform patterns which is difficult to distinguish from adenocarcinoma. Pathologic findings that provide evidence of an association between high grade PIN and prostatic carcinoma include similar architectural and cytologic features, tumor location, increased frequency, extent and severity of PIN in the presence of cancer, and immunophenotype. PIN has a high predictive value as a marker for adenocarcinoma and high grade PIN is associated with invasive carcinoma in approximately one third of patients.

Adenocarcinoma of the prostate accounts for 95% of prostate cancers. Diagnosis, as in PIN, relies on both architectural and cytologic features. Adenocarcinoma is composed of small acini arranged in one or more patterns. The acini are crowded and often have an

irregular haphazard arrangement. Cytologically there is nuclear and nucleolar enlargement. The basal cell layer is absent. Histologic grading of prostatic adenocarcinoma has been shown to be a strong prognostic factor. The Gleason grading system remains the recommended grading system and is based on the degree of architectural differentiation. Tumors are graded based on heterogeneity with the primary pattern having the dominant grade and the secondary pattern for the non-dominant grade. The score is derived from adding the two patterns (scores 2 to 10). Accurate grading is dependent on tumor volume. Needle core biopsies underestimate tumor grade in 33% to 45% of the cases and overestimates in 4% to 32%. This is mostly due to tumor sampling of the biopsy and tumor heterogeneity. Gleason score has been shown to have a positive correlation with tumor volume, preoperative serum prostate-specific antigen level, the likelihood of pelvic lymph node metastases and tumor recurrence after surgical and radiation therapy.

Immunohistochemical staining often plays a role in the diagnosis of prostate cancer in needle biopsies. Often the lesions are small and histologic diagnosis is difficult. Immunostains for high molecular-weight cytokeratin, p63 and cytokeratin 5/6 have been used to mark the presence of a basal cell layer. The basal cell layer is absent in carcinoma and disrupted in high grade PIN. Alpha-Methylacyl CoA-racemase (AMACR) stains the cells of adenocarcinoma but not typically benign prostate glands. Recent studies have shown the usefulness of a combination of basal cell markers and AMACR in aiding the diagnosis of prostate carcinoma.

# Imaging Prostate Cancer

Leping Pu, MD *Radiologist*

Prostate cancer is the most common cancer in men. Imaging for prostate cancer currently plays a major role in diagnosis, staging, monitoring of treatment and direct focal therapy. The aim of this article is to review the progress that has been made in prostate cancer imaging to date.

## Current Imaging Modalities:

**Transrectal ultrasonography (TRUS)** is the most commonly used modality in patients who present with elevated PSA levels or abnormal digital rectal examination findings. TRUS can be used to locate lesions in the prostate, help guide biopsy needles to involved areas as well as placement of brachytherapy seeds.

**CT** is mainly used for the detection of extracapsular extension, bony involvement and nodal staging.

**Anatomical MRI** has better soft tissue resolution than any other imaging method, which enables more accurate lesion detection, direct visualization of extracapsular extension and local staging. MRI is also superior to bone scan in evaluating bone metastasis but is impractical for routine total body surveys.

**Functional MRI** modalities include Dynamic contrast-enhanced MRI (**DCE-MRI**), MR spectroscopic imaging (**MRS**) and diffusion-weighted MRI (**DW-MRI**), which are also complementary in local staging.

**DCE-MRI** evaluates the vascularity and permeability of tumors with a contrast agent. Tumors show early enhancement and early washout of the contrast agent.

**MRS** provides information about the cellular metabolites. Prostate cancers have increased levels of choline and decreased levels of citrate. Thus, the ratio of choline to citrate is an index of malignancy. Integration of MRS into routine prostate MRI practice has improved tumor detection rates and helped detect recurrence after therapy.

**DW-MRI** evaluates the motion of free water in tissues. Tissue water diffusion is restricted in tumors because of increased cellularity and diminished extracellular spaces. Thus, prostate cancer detection can be improved with the use of apparent diffusion coefficient maps (ADC map) which reflect the amount of diffusion present.

**Radionuclide Imaging** for prostate cancer is still evolving.

**Bone Scintigraphy** with technetium-99m methyl diphosphonate is the most common type of imaging performed to delineate osseous metastases in prostate cancer patients with PSA levels > 10 ng/mL.

**ProstaScint Scan** is immunoscintigraphy which is used to reveal extraprostatic disease. ProstaScint scans frequently yield false-negative results, but the specificity of the study may be improved when combined with single photon emission CT (SPECT) imaging or CT scanning.

**FDG-PET** is emerging as an important modality in treatment follow-up. PET is better than either bone scanning or CT for differentiation between “active” bone metastasis and healing bone. FDG PET-CT scans are used in the evaluation of nodal disease. New radiotracers that target

tumor proliferation, membrane turnover and amino acid transport are now under investigation.

Nevertheless, MRI is currently the most accurate imaging method for lesion detection and local staging. Although experience is limited, PET with novel tracers may enable better lesion delineation and nodal staging than MRI. Real-time

transrectal ultrasonography and MRI fusion guidance can be performed at a lower cost and faster than real time MRI-guided prostatic interventional procedures. Integration of sophisticated imaging techniques into prostate interventions will allow accurate sampling and minimally invasive, targeted treatments for localized prostate cancer.

## Role of Surgery

**Eric S. Weise, MD** *Urologic Oncologist*

Adenocarcinoma of the Prostate is the most common cancer in American men and the second leading cause of death. Recent developments include screening recommendations and updated surgical options.

### Screening

Prostate Cancer is most commonly diagnosed as a result of screening. Prostate Cancer Screening consists of an annual digital rectal exam (DRE) and prostate specific antigen (PSA). Updated guidelines include screening for all men over 40 (rather than 50, as in the past). Also, there is no longer a single threshold PSA value which should prompt a prostate biopsy. These changes are related: The increased emphasis on PSA derivatives, such as PSA velocity (rate of change over time) makes a longer PSA history desirable. Earlier screening also allows for the identification of curable cancer at a young age when the benefit is greater compared to a similar cancer found later in life.

Some controversy persists. Urological, Cancer and Primary Care society recommendations all emphasize the importance of patients being informed of risks and benefits of screening. Prostate

Cancer Screening has been shown to decrease prostate cancer deaths in population based longitudinal studies. However, screening may lead to over-treatment. Very early low grade cancer, particularly in older men, may not require active treatment and may be best managed with close observation only. The underlying problem is that our current diagnostic accuracy and prognostic tools are sub-optimal. Many patients therefore err on the side of caution when making their management decisions. And for good reason: In current clinical practice, a man diagnosed with a cancer that appears early and low grade has a risk as high as one in six of actually having a high volume/high grade cancer.

### Robotic Surgery

Radical Prostatectomy is considered the gold standard for treatment of localized prostate cancer. To be a candidate for surgery, a patient should have a life expectancy of ten years. The average 75 year old man alive today has a life expectancy of twelve years. Treatment of prostate cancer with radiation can benefit men of any age and is the primary choice for a man too old or too unhealthy for prostate surgery.

Over the past ten years removal of the prostate has become a high tech procedure. Robotic surgery is the commonly used term for what is technically more accurately described as a computerized master – slave surgical interface: The surgeon first places a camera and instruments into the body through very small openings in the skin. The prostate removal is then accomplished by operating the instruments through a computer console that provides a 3D view of the operative field.

Benefits of robotic surgery include improved recovery. Patients walk and eat hours after surgery and rarely remain in the hospital for more than one night. Many patients use no narcotics after going home. Return to work ranges from days to 4 weeks, depending on occupation. The more important benefits of robotic surgery may result from the highly magnified optics and the micro

instruments, which facilitate meticulous surgical technique, important for cancer control and the minimization of potential changes to urinary and sexual function. A state of the art robotic system has very recently been installed at Good Samaritan Hospital.

Erik S. Weise, MD, is a urologist with fellowship training in urologic oncology and in robotic and laparoscopic surgery. He has been in practice for five years, dedicated to caring for patients with cancer of the prostate, kidney and bladder and has performed over 1000 robotic procedures. Dr. Weise recently became part of Dayton Physicians, LLC where he has joined David W. Key, MD, Mark A. Monsour, MD and Michael K. Yu, MD, on the existing robotic team. Dr. Weise is on staff at Good Samaritan Hospital.

# Chemotherapy and Other Drug Therapies for Prostate Cancer

**John Haluschak, MD** *Medical Oncologist*

Historically, once a prostate cancer metastasized, treatment was limited to techniques of depriving the cancer of testosterone (referred to as hormone sensitive recurrent prostate cancer) or chemotherapy (hormone resistant prostate cancer recurrence). Chemotherapy in simple terms, kills markedly abnormal and immature cancer cells but generally is associated with side effects from damaging, or to a limited degree, killing normal cells. Currently the majority of new medications approved for cancer treatments are not chemotherapy but are considered instead to be targeted drugs. This includes, but is not limited to, drugs that may enhance the immune system like Provenge for prostate cancer, drugs that inhibit growth proteins like tyrosine kinase necessary for cancer to survive (like Sutent), antiangiogenesis drugs that essentially stop a tumor's ability to grow by negating its ability to develop a blood supply like Avastin, or by targeting other unique proteins critical to a cancer cell's survival. Many examples have been commercially available for other cancers like lymphoma or breast cancer.

In the last 20 years treatment options have been limited for patients with advanced or recurrent prostate cancer to hormone directed therapies – and more recently the chemotherapy agent Taxotere. But this year alone two new agents are commercially approved for prostate cancer. The first was Provenge, the first commercially based immune therapy for any cancer beyond biologic response modifiers. Unlike most chemotherapy, Provenge is extremely well tolerated. The patient must have their blood collected with a technique called Apheresis. The only approved site

in Indiana and the majority of Ohio is the Dayton Community Blood Center. That unfortunately means patients at Indiana University or in Cincinnati are required to undergo Apheresis at a Dayton Community Blood Center location. In Dayton and surrounding communities, we are pleased to point out that the only site approved for providing the actual office treatment is at Good Samaritan North Health Center.

Another new drug is Jevtana, a chemotherapy agent with fewer long term side effects than those seen with Taxotere – the previous standard for many years. This product, since approved a couple of months ago, has been used at Good Samaritan North Health Center more than anywhere else in Dayton, reflecting the cutting edge treatment at Good Samaritan.

We continue to study new drugs in the treatment of prostate cancer, including a promising oral enzyme inhibitor that's undergoing the last stages of national testing (referred to as phase III clinical studies). If made available for compassionate use, we certainly will be discussing this product – Abiraterone.

Prostate cancer therapy is definitely more promising compared to a couple of years ago, The Samaritan Cancer Center at Good Samaritan North Health Center remains one of the stronger programs in Ohio for prostate cancer patients. New drugs used in treating prostate cancer will continue to be pursued and available at Good Samaritan North Health Center as our physicians work with leading prostate cancer physicians across the country.

# Treatment of Prostate Cancer with Radiation Therapy

**Greg Rasp, MD** *Radiation Oncologist*

Radiation therapy plays a central role in the treatment of prostate cancer for all stages of disease. Early stage patients, (Stage I and II) have an option of proceeding with radiation therapy, either through external beam treatments or internal brachytherapy treatments to try to cure their prostate cancer. As the stage becomes more aggressive from Stage I and II to Stage III, in general patients receive radiation therapy, as surgery becomes less of a viable option or alternative. Stage IV patients can be treated with radiation therapy for palliation of metastatic pain to the bones. Prostate cancer has a general tendency to metastasize to central bones of the pelvis and spine, often resulting in debilitating pain. Local radiation therapy is very effective at controlling this problem. Ultimately systemic radionuclides like Samarium or Strontium can be used to treat widespread bony metastatic disease. Finally, radiation therapy can be used in the setting of salvage after failure of prostatectomy. Patients who have close or positive margins, extracapsular disease, or seminal vesicle involvement should receive radiation therapy fairly promptly after recuperating from surgery. Randomized studies have shown significant improvements in disease free survival with the addition of adjuvant radiation therapy in that setting. Another group of patients that can receive radiation therapy are those patients found incidentally at surgery to have positive lymph nodes in the pelvis. Pelvic radiation therapy has been shown to improve local control and may in some rare instances salvage the Stage IV patient and cure them.

There are a wide variety of treatment techniques for prostate cancer. Because the prostate is a mobile structure, external beam therapy had historically suffered from an inability to localize the prostate on a daily basis. Changes in

bladder and bowel volume can move the prostate more than 2 cm. in the anterior to posterior and superior to inferior directions. Until the advent of image guided techniques to monitor the exact location of the prostate from day to day, external beam portals were prohibitively large or missed the target on any given day. This led radiation oncologists to advise patients to undergo brachytherapy. While brachytherapy is an excellent option for treatment of low grade prostate cancer, there were many subgroups of patients who could not receive adequate care with brachytherapy.

New techniques evolved to locate the prostate from day to day. Primitive techniques like ultrasound through the abdominal wall had some improvement in localization. More advanced techniques like placing gold fiducial markers into the prostate or RFIG tags into the prostate allow for a much greater degree of accuracy. Because of this, tight radiation portals could be used with diminished toxicity. Finally, technologies like megavoltage CT scanning on a daily basis have become standard. This allows for accuracy to within 1 mm.

In parallel with the advances of image guidance, a generational improvement in treatment planning has occurred as well. Initial radiation portals were designed by physicians using three dimensional volumes. Unfortunately each of these volumes would receive a uniform intensity. The end result was that normal tissues like the rectum and bladder would end up receiving relatively large fractions of the prescribed dose of radiation therapy. Intensity modulated radiation therapy (IMRT) allowed the physician to designate target doses and to allow a highly advanced computer and artificial intelligence technology to find the very best angles of approach and differential intensity across the beam front.

The combination of IMRT and IGRT has allowed for unprecedented control of the radiation beams, superb accuracy, elevated doses to malignant tissue, and diminished side effects and complication rates.

Good Samaritan Hospital has been on the cutting edge with each of these improvements and offers the full array of both external beam and brachytherapy options for your patient.

## Clinical Trials

**Howard Gross, MD** *Medical Oncologist*

### **Principle Investigator, Dayton Clinical Oncology Program**

Good Samaritan Hospital is a major contributor to the Dayton Clinical Oncology Program (DCOP). The majority of its physicians who treat cancer patients participate in the program either as referring or treating physicians. DCOP is one of approximately fifty community clinical oncology programs throughout the country funded by the National Cancer Institute offering treatment, cancer control, and prevention trials for most of the major types of cancer including hematological malignancies. Trials are available from six national research bases as well as the Clinical Trials Support Unit (CTSU) directly administered by the NCI. There are currently sixteen member institutions that participate with DCOP including Wright State University School of Medicine, and hospitals in Indianapolis, Indiana, and Findlay, Ohio. The most recent member to participate is the Neuroscience group from the University of Cincinnati.

208 patients were accrued to treatment and cancer control trials by DCOP Physicians in 2009. Good Samaritan Hospital had the most accruals at fifty-five. Four of the top seven accruing physicians were GSH based physicians. Howard Gross, MD continues as the Principle Investigator of DCOP since 1990. Katherine Peyton, RN, OCN and Eileen Flynn, RN, BSN, OCN are the current Oncology Research Nurses serving Good Samaritan Hospital and Good Samaritan North Health Center.

DCOP currently has one Prostate Cancer protocol available but several more are expected to be approved in the near future. To have a patient evaluated for study or if you have questions about DCOP call the DCOP office at (937) 775-1350 or contact one of the research nurses at (937) 734-5847.

# Genetics of Prostate Cancer

Faith Callif-Daley, MS, CGC

Family history has long been recognized as a risk factor for prostate cancer. Families with multiple affected men have been reported, and men with close relatives with prostate cancer are at greater risk for developing the disease themselves, especially if their relatives are younger when diagnosed. About 5% of men with prostate cancer meet the Hopkins criteria for Hereditary Prostate Cancer (HPC): (1) three or more first-degree relatives (father, brother, son), or (2) three successive generations of either the maternal or paternal lineages, or (3) at least two relatives affected at age 55 years or younger.

Families meeting the Hopkins criteria are valuable for researchers of the International Consortium for Prostate Cancer Genetics (ICPCG) who are dedicated to discovering prostate cancer susceptibility genes. A number of prostate cancer susceptibility genes have been identified in research families, but currently the clinical usefulness of these gene tests is not known, and they are not available outside the research realm. Among them are the following genes: RNASEL/HPC1, PCAP, HPCX, CAPB, and HPC20. In contrast, families with both breast and prostate cancers may have mutations in BRCA1, BRCA2 or CHEK2 genes. Identifying a patient with a BRCA1, BRCA2 or CHEK2 mutation can lead to clinically relevant risk assessment information and related cancer prevention recommendations for patients with prostate cancer and their families.

Most cancer genetic studies have concentrated on identifying prostate cancer susceptibility gene mutations which are uncommon in the population but significantly increase prostate cancer risk. An additional approach is to identify gene variations which are more common in the population but are associated with small increased risks for prostate cancer.

New genetic tests have been developed from the latter research in which multiple single nucleotide polymorphisms (SNPs) are evaluated by a laboratory and individualized risks for prostate cancer are provided which are independent of family history. For instance, one patient may have a lifetime risk for prostate cancer of 8% while another might have a lifetime risk of almost 50% based on their particular SNPs. Currently, the American Society of Clinical Oncology cautions against the use of such tests, because they are of uncertain clinical utility. The correlations between the SNPs and the prostate cancer risk are uncertain. Additional SNPs or susceptibility gene mutations may be more important and it is unclear how various risk stratifications should affect prostate cancer screening or prevention guidelines.

Current NCCN guidelines call for cancer screening modifications based on race, age and family history. At this time, genetic testing has little additional utility for modifying prostate cancer screening and early detection guidelines.

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Robson ME, et al American Society of Clinical Oncology Policy Statement Update: Genetic and Genomic Testing for Cancer Susceptibility. *J Clin Oncol* 28(5): 893-901, 2010.

## Lung Cancer Program

**Diane Tousignant, RN, BSN** Lung Cancer Care Coordinator

The Lung Cancer Program at Good Samaritan Hospital provides our patients with coordinated multidisciplinary care. Our team of specialists consists of pathologists, radiologists, pulmonologists, medical oncologists, radiation oncologists, thoracic surgeons, nurse coordinator, clinical trials nurses, oncology social worker, dietitian, pastoral care, and oncology data managers. The lung cancer program goal is to guide our patients through their treatment with as much ease and efficiency as possible while we educate, support, and care for them.

Our quality goals for 2009 were:

1. 100% of patients who undergo thoracotomy will have preoperative evaluation per NCCN guidelines.
2. Adequate mediastinal lymph node sampling will be maintained at 80%.
3. 60% of all new lung cancer cases will be presented at lung conference.
4. Within three months and prior to surgical resection, 100% of patients will undergo pulmonary function testing.
5. Analyze the first half of 2009 cases to determine the percentage of patients with an interval of greater than 20 days between positive pathology (tissue diagnosis) and the first treatment. Plan and/or implement strategy based on study outcome, to improve/decrease the time interval.

A weekly lung cancer conference is held to discuss interesting or complex lung cancer cases. Our multidisciplinary team of physicians, surgeons, pulmonologists, radiologists and pathologists enjoy an open forum of discussion and collaborate to attain quality treatment planning while adhering to the National Comprehensive Cancer Network (NCCN) guidelines of cancer care.

I continue to monitor all abnormal chest X rays. Although not yet conclusive, research is suggesting that a high rate of early lung cancer detection may be possible using X ray technology. I am reading all chest X ray reports and facilitating those patients with abnormal results into the health care system with timely consultations and recommendations for diagnostic testing.

I meet with all newly diagnosed lung cancer patients and provide them with education and support regarding their disease and its treatments. Each lung cancer patient receives Good Samaritan Hospital's Lung Cancer Resource Guide, *A Journey to Hope and Healing*. Utilizing the expertise of our multidisciplinary team this guide was recently revised to include new sections on symptom management, nutritional tips, and new information on radiation therapy, chemotherapy, and targeted therapy.

## Breast Cancer Program

**Thomas Heck, MD, FACS** *Medical Director*

**Ann Lensch, RN, BSN, MS, CBCN** *Breast Care Coordinator*

The Breast Cancer Program at Good Samaritan Hospital continues to provide patients with a comprehensive approach to their care. The multidisciplinary team works together for the benefit of each patient diagnosed and treated. Each new case is presented to our weekly breast cancer multidisciplinary conference or reviewed by the program Medical Director. Our team consists of medical oncologists, radiation oncologists, surgeons, radiologists, pathologists as well as other support staff. The recommendations from this conference are based on nationally accepted guidelines provided by the National Comprehensive Cancer Network (NCCN).

The Breast Cancer Program was certified by The Joint Commission first in May 2007 and renewed in 2009. Good Samaritan Hospital was the first in the nation to receive this certification for breast cancer care. The program was also certified by the American College of Surgeons' National Accreditation Program for Breast Centers (NAPBC) in 2009.

Our award winning breast cancer book *A Woman's Journey Toward Healing* was revised with the help of many physicians on our team. This book provides valuable information to all newly diagnosed patients. The book includes information on breast cancer, treatment options and many resources to help a woman through her breast cancer journey. This book now includes a chapter on survivorship which helps to educate women on their individual treatment and the expectations for their future.

Our comprehensive Samaritan Breast Center includes all breast imaging modalities as well as a surgeon, who specializes in breast diseases. The surgeon performs biopsies when indicated and counsels patients and their families on treatment options when cancer is diagnosed. Breast imaging studies can be readily reviewed with the Samaritan Breast Center radiologists and the results shared immediately with the patient. This collaborative approach has resulted in markedly decreasing the time it takes to make a diagnosis and establish a treatment plan.

### **High Risk Breast Cancer Program**

Our High Risk Breast Cancer Program, established in 2008, was the first in the region. This program helps women determine whether they are at high risk for breast cancer. Our team includes a general surgeon who specializes in breast care, dedicated radiologists, a medical oncologist, a certified genetic counselor and a breast care coordinator. Those who enter the program have their medical history and family history evaluated by the surgeon and genetic counselor. An assessment is completed and imaging studies are ordered if indicated. The patient is then counseled and risk reduction strategies are discussed and implemented as needed.

### **Breast Cancer Fund of Ohio**

Many patients of the Samaritan Cancer Center benefited from the Breast Cancer

Fund of Ohio. This grant gives temporary help to breast cancer patients who have limited or no resources for transportation to and from treatment, living expenses, utility payments, and treatment costs such as prescriptions and insurance co-pays.

These grant funds are obtained through the sale of a special breast cancer license plate. ([www.breastcancerfundofohio.org](http://www.breastcancerfundofohio.org))

### **SOS- Sharing Our Strength**

The Samaritan Cancer Center holds a breast cancer support group which meets each month at Good Samaritan North Health Center. A guest speaker provides education for the attendees and a sharing session follows. Anyone with a breast cancer diagnosis, past or present is welcome to attend. A support person may accompany them as well.

## Melanoma Program

**Diane Tousignant, RN, BSN** *Melanoma Program Coordinator*

The melanoma program is another of Good Samaritan Hospital's multidisciplinary coordinated programs of comprehensive care.

This program provides our patients with timely evaluation and clinical management following National Comprehensive Cancer Network (NCCN) guidelines. Availability of clinical trials for new treatment modalities and referral to our on-site certified genetics counselor are two of the program components.

Our multidisciplinary team consists of general surgeons, plastic surgeons, dermatologists, medical oncologists, radiation oncologists, pathologists, nurse coordinator, clinical trials nurse, genetics counselor, and oncology social worker.

Referrals are made to the program from a primary care physician or dermatologist. Care is delivered at either Good Samaritan Hospital or Good Samaritan North Health Center. Once treatment is complete, the patient is then released to the referring physician for follow up care.

Samaritan Cancer Center continues to provide our community with the opportunity to participate in a free yearly skin screening. We look forward to working in our community and welcome the challenge of caring for melanoma patients in Montgomery County and our surrounding northern communities.

## Medical Oncology/Infusion Services

**Bobbie Martin, MS, RN** *Director, Oncology Services*

The Medical Oncology/Infusion Services area of the Samaritan Cancer Center provides care for patients receiving chemotherapy, blood transfusions, other IV medications and minor procedures on an outpatient basis. Collaboration between our In-patient Oncology services and the Cancer Center provides continuity of care for our patients throughout their illness.

The Oncology Certified Nurses in the Cancer Center have the expertise to assess, educate, support and provide the highest quality of care to our patients. These nurses collaborate with members of a multidisciplinary team to provide knowledge, compassion, and hope to our patients and families. The multidisciplinary team consists of care coordinators, a social worker, pharmacists, dietitians, chaplains, genetics counselor and, by

referral, home care services including Hospice, physical therapists, and psychologists.

The Infusion Services staff also supports physician specialists and their patients in the Cancer Center's specialty clinics. These specialists include Drs. Sorg, Starrett, and Sabaugh, Infectious Disease. Dr. Albright, Neuro Oncologist, and the Medical Oncologists of Dayton Physicians, LLC Hematology and Oncology Division who, along with the Oncology Fellows, manage the medical oncology clinic.

Through the collaborative work of the Infusion staff, Pharmacists, and playing a lead role, our Oncology Social Worker, we continue to receive significant free drug replacement for our patients.

## Radiation Oncology

**Gregory Rasp, MD** *Medical Director, Radiation Oncology\**

Our facility focused this year on increasing our capabilities with the installation of another state of the art linear accelerator from Varian. This machine is capable of the latest image guided radiation therapy allowing for unprecedented precision. We continued our belief that using the finest equipment coupled with a caring environment will bring patients the best possible outcomes.

Image Guided Radiation Therapy (IGRT) is the cornerstone of the 21st century radiation oncology facility. There are a number of ways to obtain information about the location of the target volume or tumor in our field. We were the first in Ohio to embrace this technology in 2002 and have continuously fine tuned it since then. While it is expensive to maintain this cutting edge technologically, we believe that those extra millimeters of precision make a huge impact on the quality of life of our patients.

Intensity Modulated Radiation Therapy (IMRT) continues to allow us to be more discriminating in our treatments. Patients today receive 80% less radiation to some structures than they did prior to the advent of this exciting technology. We are now taking it a step further and using the precision of IGRT and the discriminating power of IMRT to treat our patients faster over a shorter course time. This new approach called Stereotactic Body Radiation Therapy (SBRT) allows us to treat lung cancer patients in as few as three treatments.

As we look forward into the future, our physicians and administration are constantly searching for technologies that will improve our patient care. At Samaritan Cancer Center, patient care is what it is all about.

*\*Dayton Physicians, LLC*

# Support Services in the Samaritan Cancer Center

**Bobbie Martin, MS, RN** *Director, Oncology Services*

## Man to Man

“Man to Man” is a Prostate Cancer Education and Support Program of the American Cancer Society. Meetings are held the second Monday of every month from 6:30 p.m. to 8 p.m. in the Education Center at Good Samaritan North Health Center. “Man to Man” provides a comfortable, confidential meeting environment that encourages men and their families to discuss their concerns openly and honestly and to share solutions to common problems. Members of “Man to Man” receive personal visits and telephone support from specially trained prostate cancer survivors as well as an informative newsletter.

## Look Good...Feel Better

Look Good...Feel Better is an American Cancer Society program available free of charge to women. Volunteer cosmetologists teach women who are receiving chemotherapy or radiation how to cope with skin changes and hair loss. Women receive a free make up kit during class. The program is held at Good Samaritan North Health Center quarterly in rotation with other area hospitals, and greatly appreciated by the women who participate.

## Introduction to Radiation Therapy

This unique class was introduced to provide patients and their loved ones with general information regarding radiation treatments and the complex process that is involved in providing this therapy. Goals of the program are:

- To learn general information about radiation.
- To create lasting bonds so the patient and their family feel the Samaritan Cancer Center's care and concern.
- To empower the patient and their loved ones with support, knowledge and an understanding of the process for receiving radiation therapy.

Patients and their families receive a tour of the facility, including especially the radiation treatment area. The program is held every Tuesday at 4 p.m. in the Samaritan Cancer Center. Patients and their families are welcome to attend the program. It is a time for them to ask questions and to see the technology used for treatment.

## Living With Cancer Support Group

The Living With Cancer Support Group is offered on the first Monday of each month at Good Samaritan North Health Center from 6 p.m. to 8 p.m. Debra Felter, RN, OCN and Jane Thomas, RN, OCN from Infusion Services and Sister Rosemary Goubeaux, Pastoral Care Chaplain, are the facilitators. Patients and their support persons may attend in order to share with and provide support to others who are experiencing common concerns and feelings. Guest speakers address topics suggested by the participants.

## Camp Samaritan

Camp Samaritan is a wellness retreat for adults living with cancer that is supported by the Samaritan Health Foundation. Camp is held once each year and run by volunteer physicians, nurses, and staff. It provides cancer patients and their support persons with educational and recreational activities aimed at coping with their illness. Most importantly, they are able to share with others who are facing similar issues and concerns in a relaxed environment.

The camp also enables adults diagnosed with cancer and their loved ones who are coping with cancer to get away for a weekend, to meet others who share their concern, and focus on themselves, rather than on their disease. Thanks to continued funding from the Samaritan Health Foundation, we continue to offer this weekend at a cost of only five dollars per camper.

## Oncology In-Patient Care

**Bobbie Martin, MS, RN** *Director Oncology Services*

In-patient oncology care is dedicated to patient-focused, holistic care of those individuals diagnosed with cancer. Care is administered by a team of healthcare professionals that includes physicians, oncology certified nurses, dietitians, pharmacists, pastoral care staff, social workers, case managers and physical therapists. These individuals are knowledgeable about the unique needs of the oncology patient. They provide not only physical care to the patient, but also emotional and spiritual care, education and guidance to both patients and family members.

Patients are admitted across the disease continuum for interventions such as symptom management, chemotherapy and palliative care. Ten dedicated patient rooms are available, with two of them having special air-flow systems designed to meet the needs of immunocompromised patients. Bi-weekly interdisciplinary rounds and a collaborative relationship between the in-patient and out-patient settings is what sets the Samaritan Cancer Center apart from other programs.

## Oncology Rehabilitation Services

**Katie Elliott,** *Director of Rehab Services*

**Theresa Walchner PT, CLT-LANA; Ellen Moler PT, CLT-LANA; Wendy O'Shea PT**

Good Samaritan North Health Center's Physical Therapy staff can help cancer survivors face many of the challenges that they encounter both during and after cancer treatment. During cancer treatments, Physical Therapy can assist patients in maintaining physical well-being and functional independence, as well as reduce pain and discomfort. After cancer treatment is completed, Physical Therapy focuses on regaining function, improving strength, and decreasing fatigue. Lymphedema prevention and management is also available as deemed appropriate following surgical intervention or cancer treatments.

Our specially trained & dedicated Physical Therapists in our Oncology Rehab Program assist patients in managing the following issues:

- Physical well-being
- Impaired mobility, deconditioning, weakness, loss of flexibility
- Energy management issues, including cancer-related fatigue

- Chemotherapy-related side effects, including neuropathy, gait abnormality, and balance problems

- Lymphedema

Specific interventions include:

- Mobility training
- Increasing muscle strength and stamina
- Range of motion exercises
- Stretching of radiated joints and tissues/post-radiation fibrosis
- Scar management
- Reduction of pain and prevention of muscular pain syndromes
- Equipment recommendations
- Balance and coordination
- Fall prevention
- Energy conservation
- Sleep hygiene
- Endurance training
- Lymphedema management

## Pastoral Care

**Sr. Rosemary Goubeaux, CPPS** *Chaplain*

Pastoral Care is an important component of the holistic health care team for oncology patients. Chaplains provide ministry of presence which includes assessing spiritual and emotional needs of patients and their families. Spirituality is often a powerful force in one's understanding of the meaning and quality of life as well as the healing process. The chaplain is there to assist and encourage the patient in responding to these needs.

The following services are available to oncology patients at Good Samaritan Hospital and the Samaritan Cancer Center:

- Ministry of presence
- Counsel, conversation and spiritual companionship
- Encouraging patients to tell their story
- Private prayer with patients
- Resource for ethical issues
- Assistance in developing a support system with their faith community
- Providing a Bible and other reflective materials
- Rituals such as sacraments, anointing, reconciliation, Eucharist
- Music, guided imagery, healing touch for relaxation
- Emotional and spiritual support to families
- Support group services

## Social Services

**Constance Ickes, LISW-S** *Oncology Social Worker*

As the Oncology Social Worker, I am available in the Samaritan Cancer Center to assist cancer survivors and their families with psychosocial issues from referral to post treatment. These issues include adjustment to the diagnosis, managing within the healthcare system, financial assistance and increased need for community resources such as transportation and home health care. As a result of the psychosocial assessment with a focus on identifying strengths, I can provide a range of services including supportive counseling, financial counseling, review of and referral to appropriate community agencies, education about support groups and advocacy.

My focus is on the needs of the whole person and helping them navigate the health care system. When patients and families cannot afford their medications, I assist the patient in accessing sources of reimbursement. Examples include pharmaceutical assistance programs, national foundations and local community programs. Our team has been very successful in working with the pharmaceutical assistance programs to obtain free drug replacements. This program and the process involved has been shared with the other hospitals of Premier Health Partners.

# Nutrition and Prostate Cancer

**Martha Grodrian RD, LD, CDE**

Modifiable risk factors for Prostate Cancer have a strong nutritional component:

- Excessive calorie intake resulting in abdominal obesity
- Diets low in fiber, low in plant foods, and high in saturated fats
- Overconsumption of dairy products and red meats leading to increased levels of phytanic acid

Vitamin D as 1,25-hydroxyvitamin D<sub>3</sub> may inhibit the spread of prostate cancer cells. The increasing prevalence of marginal to low vitamin D status among men, especially African Americans, may be a contributing factor. The RDA was based on prevention of rickets, which requires a minimal amount of vitamin D and which may not be the optimal level for cancer prevention and good health. New recommendations are expected in fall 2010.

Protective foods include fruits, vegetables, herbs, spices, nuts and seeds, green tea, and whole grains which are rich sources of these nutritionally based phytochemicals known to help in prevention of prostate cancer:

- Apigenin (parsley, celery, chamomile)
- Lycopene (tomatoes, watermelon, strawberries) – best absorbed from cooked foods with a small amount of healthy fat
- Curcumin (turmeric)
- Cruciferous vegetables
- Epigallocatechin (green tea)
- Gamma tocopherol (walnuts, pecans, sesame seed, corn and sesame oils)
- Lignans (ground whole flax seed or flax seed oil with lignans added back)
- Quercetin (apple, onion, red grapes, cherry, citrus fruit, tomatoes, broccoli, raspberry, capers, black and green tea)
- Resveratrol (red wine, red grapes, boiled peanuts, red grape juice, cranberry juice)

- Soy genistein (soy beans and products made from them: soy milk, tofu, tempeh, etc.)
- Fish oils (DHA and EPA) from fatty fish (salmon, herring, sardines, tuna, mackerel) and fish oil supplements,
- Vitamin D<sub>3</sub> from supplements, fortified foods (milk), and modest exposure of bare skin to the sun (November – March at this latitude, skin exposure to sun cannot make D<sub>3</sub>)
- Physical activity/exercise

After a diagnosis of prostate cancer, the patient is encouraged to consult with a registered dietitian. Good nutrition augments treatment and provides a positive focus for patient and family efforts to manage the disease. Patients undergoing therapy focus on maintaining present weight by consuming nutritious foods and fluids and avoiding excesses. Adequate protein and calories prevent wasting, improve immune system, support treatment, and preserve lean tissue. Preventive problem solving can optimize nutrition status, decrease anxiety over what and how to eat, individualize meal planning to consider additional medical problems of the patient, and provide anticipatory guidance to cope with treatment-related side effects that may affect eating. Dietitians work closely with physicians, nurses, family, and other team members to provide comprehensive quality care to the patient.

Afterwards, patients are encouraged to achieve a healthy weight and active lifestyle supported by a low fat, high fiber diet with emphasis on whole plant foods (fruits, vegetables, whole grains, judicious use of nuts and seeds, and emphasis on herbs and spices as flavor enhancers), Omega 3 fats, adequate vitamin D, gamma tocopherol, and selenium (brazil nuts).

# Outreach: Premier Community Health

**Pamela M. Reichel, MS, CPW, CHES** *Executive Director*

On behalf of Good Samaritan Hospital, Premier Community Health (PCH) offers community health programs focusing on prevention, early detection and disease self-management in four chronic disease areas. One of those areas is cancer. The cancer sites targeted are breast, colorectal, skin and lung.

## Breast and Cervical Cancer

PCH houses the Breast and Cervical Cancer Early Detection Program (BCCP), which is funded by the Ohio Department of Health with a grant from the Centers for Disease Control and by the State of Ohio. This program provides free mammograms, Pap testing and advanced diagnostics for women who do not have health insurance. Other grants to PCH provided additional free mammograms for uninsured or underinsured women. In 2009, the program provided: 1,456 mammograms, finding twenty cancers and 903 Pap tests, finding nine cancers

### **My Sister's Keeper: Increasing Mammography among African American Women**

While Caucasian women get breast cancer more often, African American women die more than any other group from this devastating disease. This program, based on a model from the National Cancer Institute's database of evidence-based programs, offers women turnkey parties. These include invitations, posters, flyers, decorations, food, goody bags, door prizes and games- all about breast health.

At the end of the party, women who have not have a mammogram in the past year are asked to sign a commitment to get one. Women who cannot afford a mammogram are qualified for a free one or for

co-pay assistance. In 2009, My Sister's Keeper served 979 women at 64 parties. Of these, 926 agreed to get a mammogram.

In 2009, My Sister's Keeper won a Gold Award from the Aster Awards for Excellence in Healthcare Marketing, a Merit Award from the Healthcare Marketing Report Advertising Awards and a Bronze Award from the National Health Information Awards.

## Colorectal Cancer

To promote early detection, GSH participates in an annual colorectal cancer screening campaign called Test for Life. This program is a collaborative effort of PCH, GSH, Miami Valley Hospital, Atrium Medical Center, WDTN-TV2, Kroger pharmacies and Vectren. Test for Life distributed free fecal occult blood test kits to more than 15,000 people in 2009. Of those, 9.67% returned a results card. In 2009, Test for Life won a Bronze Award from the Healthcare Marketing Report Advertising Awards and a Merit Award from the National Health Information Awards.

## Skin Cancer

Each May, Good Samaritan Hospital collaborates with the Wright State University Boonshoft School of Medicine's Department of Dermatology, and Kettering Medical Center to offer free skin screenings at locations throughout the area. In 2009, 391 individuals received free screenings at this event, finding six basal cell cancers, one squamous cell and one melanoma. In collaboration with the Ohio State University Extension Office, we also conducted 683 Dermascan skin awareness screenings.

## **Lung Cancer Prevention and Awareness**

Individuals who smoke and are hospitalized at GSH can be referred for one-on-one counseling by respiratory therapists who are certified smoking cessation counselors. For the community, Premier Community Health offers the

services of a certified smoking cessation counselor free of charge. In 2009, seventy-four individuals received tobacco cessation counseling and had a 28.4% quit rate. We also completed 100 carbon monoxide breath tests for smokers and those who live with smokers.

## Samaritan Cancer Center Services

Cancer Education  
In Patient Acute Care  
Palliative Care  
Early Detection & Screening  
The Cancer Genetics Program  
Radiation Oncology\*  
Neuro Oncology  
Medical Oncology/Infusion Services  
Surgical Oncology  
Multidisciplinary Melanoma Program  
Clinical Trials  
High Risk Breast Cancer Program  
Breast Care Coordinator  
Lung Cancer Coordinator  
Oncology Social Services  
Oncology Rehab Services  
Oncology Data Services  
Pastoral Care  
Cancer Support Groups  
Camp Samaritan

*\*Dayton Physicians, LLC*



**Good Samaritan Hospital**  
Premier Health Partners

### **Samaritan Cancer Center**

Good Samaritan North Health Center  
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Dayton, Ohio 45415  
(937) 734-5800

[GoodSamDayton.org](http://GoodSamDayton.org)

† CATHOLIC HEALTH  
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