Samaritan Cancer Center

2009 Annual Report

with 2008 statistics

Good Samaritan Hospital
Premier Health Partners

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Introduction

Gregory Rasp, MD
Radiation Oncologist
Chair, Oncology Committee

Bobbie Martin, RN, MS
Director, Oncology Services

We are pleased to present the cancer program's annual report which we have modified by including our 2008 statistics, but adding events from 2008 and 2009.

In 2008, we were fortunate to provide the presence of a dedicated breast surgeon located within the Samaritan Breast Center at Good Samaritan North Health Center. Dr. Tom Heck, and Dr. Diane Anderson, became co-medical directors of the Samaritan Breast Center. In addition, the area's first high risk breast cancer program was formally established as the High Risk Breast Cancer Program at Good Samaritan North Health Center. While our program has benefited from the services and presence of a genetic counselor on site in the Samaritan Cancer Center for over ten years for all appropriate cancers, this program formalizes a team specific to breast cancer that includes a surgeon, medical oncologist, radiologist, breast cancer coordinator and certified genetic counselor.

These two years were busy ones for accreditations. In May of 2008 we were surveyed by the American College of Surgeons' Commission on Cancer and were accredited with commendation. In 2009 as a result of that survey we again received the Outstanding Achievement Award. Only 19% or 95 out of 478 of those programs surveyed in 2008 nationally, received this award. In Ohio, 98 programs were eligible with nine receiving this award.

In May of 2009, our breast cancer program was re-certified by The Joint Commission (originally the first in the nation) and became the second program in Ohio to be accredited in a separate survey by the National Accreditation Program for Breast Centers.(NAPBC).

Major revisions to our breast cancer and lung cancer patient education books were completed so that our patients will always be provided with the most current information. We are grateful to the physicians who took the time to review and update the information.

In these challenging economic times we continue to look for ways to provide care in the most appropriate setting and provide it cost effectively. Two initiatives have supported these efforts. First, Infusion Services in the Samaritan Cancer Center expanded its hours into the evening in order to provide out-patient blood transfusions as often as possible, avoiding the in-patient setting. Second, our oncology social worker in conjunction with the oncology pharmacists, developed a process to access all available drug savings programs. In 2008 $238,000 in drug replacement was obtained. In 2009 we project approximately $350,000 in drug replacement.

The focus of study in this report is renal cell carcinoma. This site was selected due to recent physician and patient interest in radiofrequency ablation (RFA). Our physicians and staff have as their primary goal, the development of an RFA renal cell pathway that includes selection criteria, treatment and follow-up.

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. It is our goal to continue to provide you with the area's finest cancer care.

Oncology Program Committees

Oncology Committee

Gregory Rasp, MD
Chair, Radiation Oncologist

Howard Abromowitz, MD
Urologist

Diane Anderson, DO
Radiologist

Charles Bane, MD
Medical Oncologist & Medical Director, Palliative Care

Manibha Banerjee, MD
Pathologist

Howard Gross, MD
Medical Oncologist & Coordinator, Oncology QI

John Haluschak, MD
Medical Oncologist

Shamim Jilani, MD
Medical Oncologist

Daniel McKellar, MD
Medical Director, General Surgeon & Cancer Liaison Physician, Coordinator, Community Outreach

Rebecca Paessun, MD
Radiation Oncologist

Theodore Payne, MD
Radiologist

Mohammed Shaik, MD
Internal Medicine

Laszlo Toth, MD
General Surgeon

Thav Tambi-Pillai
General Surgeon

Anita Adams, VP, MBA, RCP
Administration, VP Operations

Bobbie Martin, RN, MS
Director,Oncology Services

Connie Ickes, MSW, LISW-S
Oncology Services

Brenda McCracken, BS, CTR
Quality Control Coordinator

Deborah Hamilton, BS, RHIT, CTR
Cancer Conference Coordinator

Katherine Peyton, RN, OCN
Oncology Research Nurse

Dena Helsinger, RN, MS
Director, Center for Outcomes, Research & Clinical Effectiveness

Oncology Quality Improvement Committee

Howard Gross, MD
Chair, Medical Oncologist

Charles Bane, MD
Medical Oncologist & Medical Director, Palliative Care

Daniel McKellar, MD
Medical Director, General Surgeon & Cancer Liaison Physician, Coordinator Community Outreach

Ejaz Ahmad, MD
Pathologist

Rebecca Paessun, MD
Radiation Oncologist

Bobbie Martin, RN, MS
Director, Oncology Services

Dena Helsinger, RN, MS
Director, Center for Outcomes, Research and Clinical Effectiveness (CORCE)

Breast Cancer Steering Committee

Ann Lensch, RN, MS
Chair, Breast Care Coordinator

Diane Anderson, DO
Co-Medical Director, Radiologist

Thomas Heck, MD
Co-Medical Director, Breast Surgeon

Manibha Banerjee, MD
Pathologist

Shamim Jilani, MD
Medical Oncologist

Daniel McKellar, MD
General Surgeon

Bobbie Martin, RN, MS
Director, Oncology Services

Mindy Shelley, BSRS, RT (R) (MR) (CT) LMT
Manager, Breast Center

Roger Staton, CNMT, RT (N) (MR), MBA
Director, Diagnostics

Linda Trick
Mammographer,Breast Center

Elizabeth Maner, QA, QC
Coordinator, Diagnostics

Oncology Program Committees

Lung Cancer Steering Committee

Diane Tousignant, RN, BSN
Chair, Lung Cancer Coordinator

Mohey Saleh, MD
Co-Director, Cardiothoracic Surgeon

Howard Gross, MD
Co-Director, Medical Oncologist

Daniel McKellar, MD
General Surgeon

Aimee Russell, MD
Radiation Oncologist

Martin Ambrose, MD
Pulmonary Critical Care

Thomas Yunger, MD
Pulmonary Critical Care

Bobbie Martin, RN, MS
Director, Oncology Services

Palliative Care Committee

Charles Bane, MD
Director, Medical Oncologist

Daniel McKellar, MD
General Surgeon

Barb Standifer, RN, MHA, NEA-BC
In-patient Oncology/Palliative Care Director

Melissa Armstrong, RN, BSN
In-patient Oncology/Palliative Care Nurse Manager

Carole Smith, CNS, BC
Pain Management/ Palliative Care

Sally Clements, RN
Well-Being Center

Jeanie Heyd, RN, MS
ICU Nurse Manager

Sandra Hoskins, RN, MSN, OCN, CHPN
Education Coordinator

Joshua Cox
Clinical Coordinator, Pharmacy

Sr. Carol Bauer
Vice President, Mission Effectiveness

Craig Schneider
Coordinator, Spiritual Care

Candy Winteregg
Medical Librarian

Michelle Kitze
Clinical Dietitian, Nutrition Services

Sr. Rosemary Goubeaux
Chaplain, Pastoral Care

Chemotherapy Safety Committee

Melissa Armstrong, RN, BSN
Chair, In-patient Oncology Nurse Manager

Barb Standifer, RN, MS
In-patient Oncology Director

Howard Gross, MD
Medical Oncologist, Out-patient Medical Director

Jerry Halula, PharmD
Clinical Pharmacist

Alan Ayette, Ph.R.
Pharmacist

Susan Dodds, RN, BSN, OCN
Infusion Services, Team Leader

Bobbie Martin, RN, MS
Director, Oncology Services

Sandra Hoskins, RN, MSN, OCN, CHPN
Education Coordinator

Oncology Quality Improvement Subcommittee

Howard Gross, MD, Chair *Medical Oncologist*

The Oncology Quality Improvement (QI) Subcommittee continued its bi-monthly meetings. The committee was made up of representatives of all the subspecialties involved in the diagnosis and treatment of the cancer patient. The 2008 committee performed eight oncology QI studies. or reviews. Several of these studies are highlighted below:

1) Bladder Cancer Biopsies: All bladder cancer patients diagnosed in 2007 undergoing biopsy or Transurethral resection were reviewed to determine the adequacy of the biopsy in regards to muscle present in the biopsy specimen. This data was shared with participating urologists.

2) Limited Stage Small Cell Lung Cancer: All patients diagnosed in 2007 were reviewed to determine if they were evaluated for and/or receive Prophylactic Cranial Irradiation (PCI).

3) Stage II and III Non Small Cell Cancer of the Lung (NSCCL): All cases were reviewed to determine whether they were considered for and/or received chemotherapy.

4) Early Stage Breast Cancer patients: All breast cancer patients diagnosed in 2007 with AJCC Stage 0, I, and II were reviewed to evaluate what percent eventually underwent lumpectomy.

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 2008, 34% 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.

2008 Combined Cancer Conference Statistics	
Total Number of Conferences	138
Total Number of Cases Presented	439
Prospective Cases	436
Retrospective Cases	0
Total Number of Didactics Presented	2
Average Attendance	21
Average Medical Staff Attendance	13

2008 Head & Neck Cancer Conference Statistics	Director: Dr. Greg Rasp
Total Number of Conferences	5
Total Number of Cases Presented	24
Prospective Cases	24
Retrospective Cases	0
Total Number of Didactics Presented	0
Average Attendance	12
Average Medical Staff Attendance	8

2008 Breast Cancer Conference Statistics	Director: Dr. Thomas Heck
Total Number of Conferences	48
Total Number of Cases Presented	212
Prospective Cases	212
Retrospective Cases	0
Total Number of Didactics Presented	0
Average Attendance	23
Average Medical Staff Attendance	11

2008 Lung Cancer Conference Statistics	Co-Directors: Dr. Howard Gross, Dr. Mohey Saleh
Total Number of Conferences	42
Total Number of Cases Presented	120
Prospective Cases	117
Retrospective Cases	3
Total Number of Didactics Presented	0
Average Attendance	21
Average Medical Staff Attendance	14

2008 General Oncology Treatment Planning Conference Statistics	
Total Number of Conferences	43
Total Number of Cases Presented	83
Prospective Cases	83
Retrospective Cases	0
Total Number of Didactics Presented	2
Average Attendance	27
Average Medical Staff Attendance	17

2008 Didactic Lectures

January 4, 2008

CP3R
e-Quip Breast
e-Quip Colorectal
Dr. Daniel McKellar
Gem City Surgical Associates

Good Samaritan Hospital
Oncology Treatment Planning Conference

March 21, 2008

Hereditary Colorectal Cancer
Current Recommendations for Screening Colon Cancer
Faith Callif-Daley, MS-Certified Genetics Counselor
Laura Metzler – Early Detection Coordinator
American Cancer Society

Southwest Region, Ohio Division
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 to review 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.

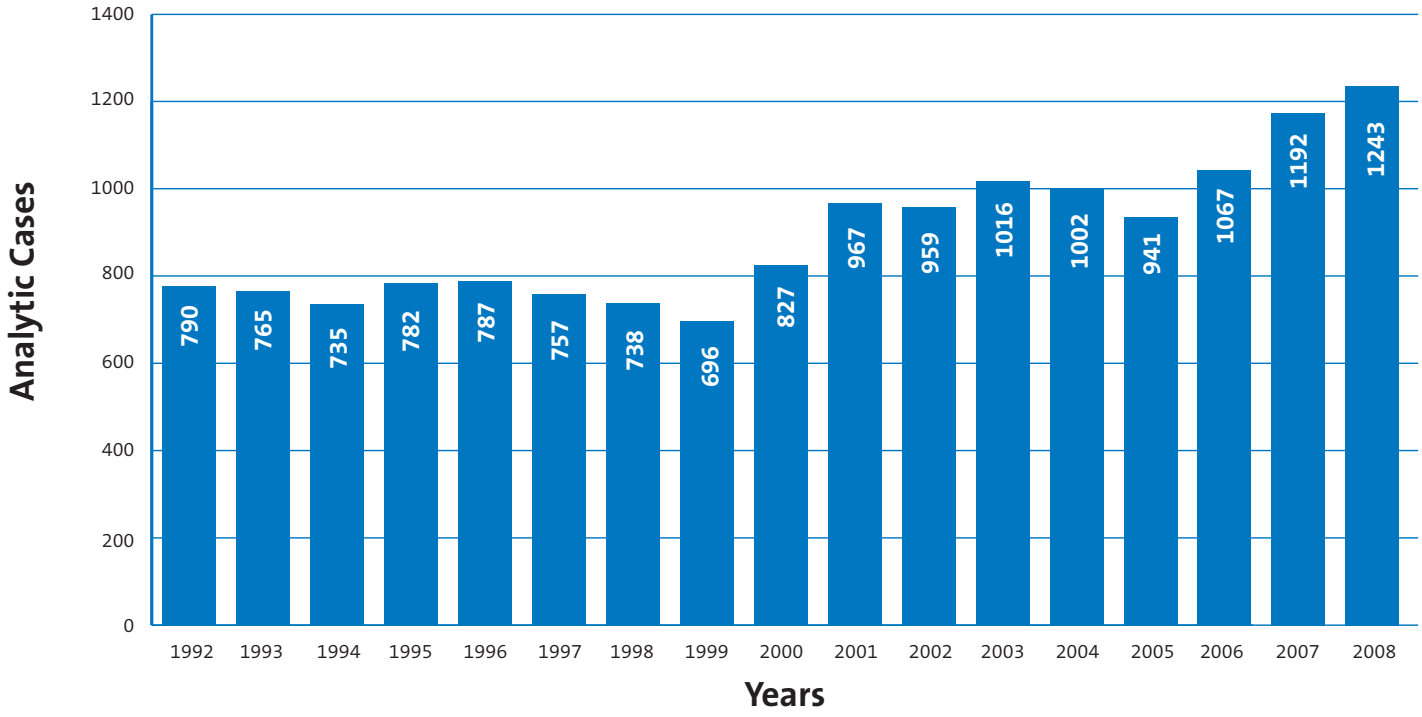
Good Samaritan Hospital Site Summary Table

Primary Site	Total Cases	Sex		Class of Case		Stage Distribution/Analytic Only						
		Male	Female	Analytic	Non Analytic	0	I	II	III	IV	Unk	N/A
Tongue	14	9	5	11	3	0	3	3	0	3	2	0
Salivary Glands	8	3	5	6	2	0	3	1	0	1	1	0
Floor of Mouth	4	4	0	4	0	0	0	0	2	1	1	0
Gum & Other Mouth	1	0	1	0	1	0	0	0	0	0	0	0
Nasopharynx	2	0	2	2	0	0	1	1	0	0	0	0
Tonsil	6	5	1	6	0	1	1	1	3	0	0	0
Oropharynx	5	4	1	3	2	0	0	1	0	2	0	0
Hypopharynx	2	1	1	2	0	0	0	0	1	1	0	0
ORAL CAVITY & PHARYNX	**44**	**27**	**17**	**35**	**9**	**1**	**8**	**8**	**6**	**8**	**4**	**0**
Esophagus	18	16	2	15	3	0	1	3	6	4	1	0
Stomach	15	11	4	11	4	0	1	2	3	5	0	0
Small Intestine	11	7	4	9	2	0	1	3	2	1	0	2
Colon Excluding Rectum	**82**	**41**	**41**	**71**	**11**	**1**	**13**	**21**	**16**	**18**	**1**	**1**
Cecum	20	11	9	17	3	0	1	10	1	4	1	0
Appendix	4	2	2	4	0	0	0	1	1	1	0	1
Ascending Colon	17	11	6	15	2	0	2	5	6	2	0	0
Hepatic Flexure	1	0	1	1	0	0	0	0	0	1	0	0
Transverse Colon	10	5	5	9	1	0	2	2	3	2	0	0
Splenic Flexure	2	1	1	1	1	0	0	0	0	1	0	0
Descending Colon	8	4	4	8	0	0	3	3	1	1	0	0
Sigmoid Colon	12	5	7	11	1	0	5	0	3	3	0	0
Large Intestine, NOS	8	2	6	4	4	1	0	0	1	2	0	0
Rectum & Rectosigmoid	**27**	**13**	**14**	**24**	**3**	**1**	**5**	**8**	**3**	**4**	**2**	**1**
Rectosigmoid Junction	7	3	4	6	1	1	1	1	0	2	1	0
Rectum	20	10	10	18	2	0	4	7	3	2	1	1
Anus, Anal Canal & Anorectum	**4**	**0**	**4**	**3**	**1**	**0**	**0**	**1**	**1**	**0**	**1**	**0**
Liver & Intrahepatic Bile Duct	10	8	2	8	2	0	2	1	4	1	0	0
Liver	7	6	1	7	0	0	2	0	4	1	0	0
Intrahepatic Bile Duct	3	2	1	1	2	0	0	1	0	0	0	0
Gallbladder	5	1	4	4	1	0	1	2	0	1	0	0
Other Biliary	5	4	1	3	2	0	0	2	0	1	0	0
Pancreas	38	21	17	32	6	0	4	6	1	21	0	0
Retroperitoneum	4	3	1	4	0	0	2	0	2	0	0	0
Other Digestive Organs	1	0	1	1	0	0	0	0	0	0	0	1
DIGESTIVE SYSTEM	**220**	**125**	**95**	**185**	**35**	**2**	**30**	**49**	**38**	**56**	**5**	**5**
Nasal Cavity, Middle Ear & Acce	**1**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Larynx	11	10	1	10	1	2	4	1	3	1	0	0
Lung & Bronchus	255	138	117	228	27	1	52	13	55	104	1	3
RESPIRATORY SYSTEM	**267**	**148**	**119**	**238**	**29**	**3**	**55**	**14**	**58**	**104**	**1**	**3**
BONES & JOINTS	**2**	**1**	**1**	**2**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**
SOFT TISSUE (including Heart)	**7**	**4**	**3**	**6**	**1**	**0**	**0**	**0**	**2**	**1**	**4**	**0**
Melanoma -- Skin	14	10	4	11	3	2	4	3	2	0	0	0
Other Nonepithelial Skin	3	2	1	2	1	0	0	0	1	0	0	1
SKIN EXCLUDING BASAL & SQ	**17**	**12**	**5**	**13**	**4**	**2**	**4**	**3**	**3**	**0**	**0**	**1**

Good Samaritan Hospital Site Summary Table

Primary Site	Total Cases	Sex		Class of Case		Stage Distribution/Analytic Only						
		Male	Female	Analytic	Non Analytic	0	I	II	III	IV	Unk	N/A
BREAST	**267**	**2**	**265**	**246**	**21**	**50**	**74**	**78**	**28**	**14**	**2**	**0**
Cervix Uteri	9	0	9	7	2	0	0	1	4	2	0	0
Corpus & Uterus, NOS	**37**	**0**	**37**	**33**	**4**	**0**	**18**	**7**	**2**	**4**	**1**	**1**
Ovary	6	0	6	5	1	0	2	0	1	1	1	0
Vulva	1	0	1	1	0	0	0	0	0	0	1	0
FEMALE GENITAL SYSTEM	**53**	**0**	**53**	**46**	**7**	**0**	**20**	**8**	**7**	**7**	**3**	**1**
Prostate	216	216	0	196	20	0	0	178	9	9	0	0
Testis	3	3	0	3	0	0	3	0	0	0	0	0
Penis	3	3	0	3	0	1	1	0	1	0	0	0
MALE GENITAL SYSTEM	**222**	**222**	**0**	**202**	**20**	**1**	**4**	**178**	**10**	**9**	**0**	**0**
Urinary Bladder	62	42	20	60	2	33	14	5	6	2	0	0
Kidney & Renal Pelvis	43	26	17	40	3	2	24	5	1	8	0	0
Ureter	1	0	1	1	0	0	0	1	0	0	0	0
Other Urinary Organs	1	1	0	0	1	0	0	0	0	0	0	0
URINARY SYSTEM	**107**	**69**	**38**	**101**	**6**	**35**	**38**	**11**	**7**	**10**	**0**	**0**
Eye & Orbit	**2**	**2**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Brain	11	8	3	3	8	0	0	0	0	0	0	3
Other Nervous System	14	5	9	12	2	0	0	0	0	0	0	12
BRAIN & OTHER NERVOUS SY	**25**	**13**	**12**	**15**	**10**	**0**	**0**	**0**	**0**	**0**	**0**	**15**
Thyroid	9	4	5	8	1	0	3	0	2	3	0	0
Other Endocrine (including Thym)	12	6	6	10	2	0	0	0	0	0	0	10
ENDOCRINE SYSTEM	**21**	**10**	**11**	**18**	**3**	**0**	**3**	**0**	**2**	**3**	**0**	**10**
Hodgkin Lymphoma	11	7	4	10	1	0	2	2	4	2	0	0
Non-Hodgkin Lymphoma	62	38	24	53	9	0	14	10	6	22	1	0
NHL - Nodal	54	36	18	46	8	0	9	10	6	20	1	0
NHL - Extranodal	8	2	6	7	1	0	5	0	0	2	0	0
LYMPHOMAS	**73**	**45**	**28**	**63**	**10**	**0**	**16**	**12**	**10**	**24**	**1**	**0**
MULTIPLE MYELOMA	**21**	**13**	**8**	**16**	**5**	**0**	**0**	**0**	**0**	**0**	**0**	**16**
Lymphocytic Leukemia	16	11	5	10	6	0	0	0	0	0	0	10
Chronic Lymphocytic Leukemia	15	10	5	10	5	0	0	0	0	0	0	10
Other Lymphocytic Leukemia	1	1	0	0	1	0	0	0	0	0	0	0
Myeloid & Monocytic Leukemia	9	6	3	9	0	0	0	0	0	0	0	9
Acute Myeloid Leukemia	8	5	3	8	0	0	0	0	0	0	0	8
Chronic Myeloid Leukemia	1	1	0	1	0	0	0	0	0	0	0	1
LEUKEMIAS	**25**	**17**	**8**	**19**	**6**	0	0	0	0	0	0	**19**
MESOTHELIOMA	**2**	**1**	**1**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
UNKNOWN PRIMARY	**40**	**18**	**22**	**36**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**36**
Total	**1415**	**729**	**686**	**1,243**	**172**	**94**	**252**	**363**	**171**	**236**	**19**	**108**

Analytic Cancer Cases 1992-2007



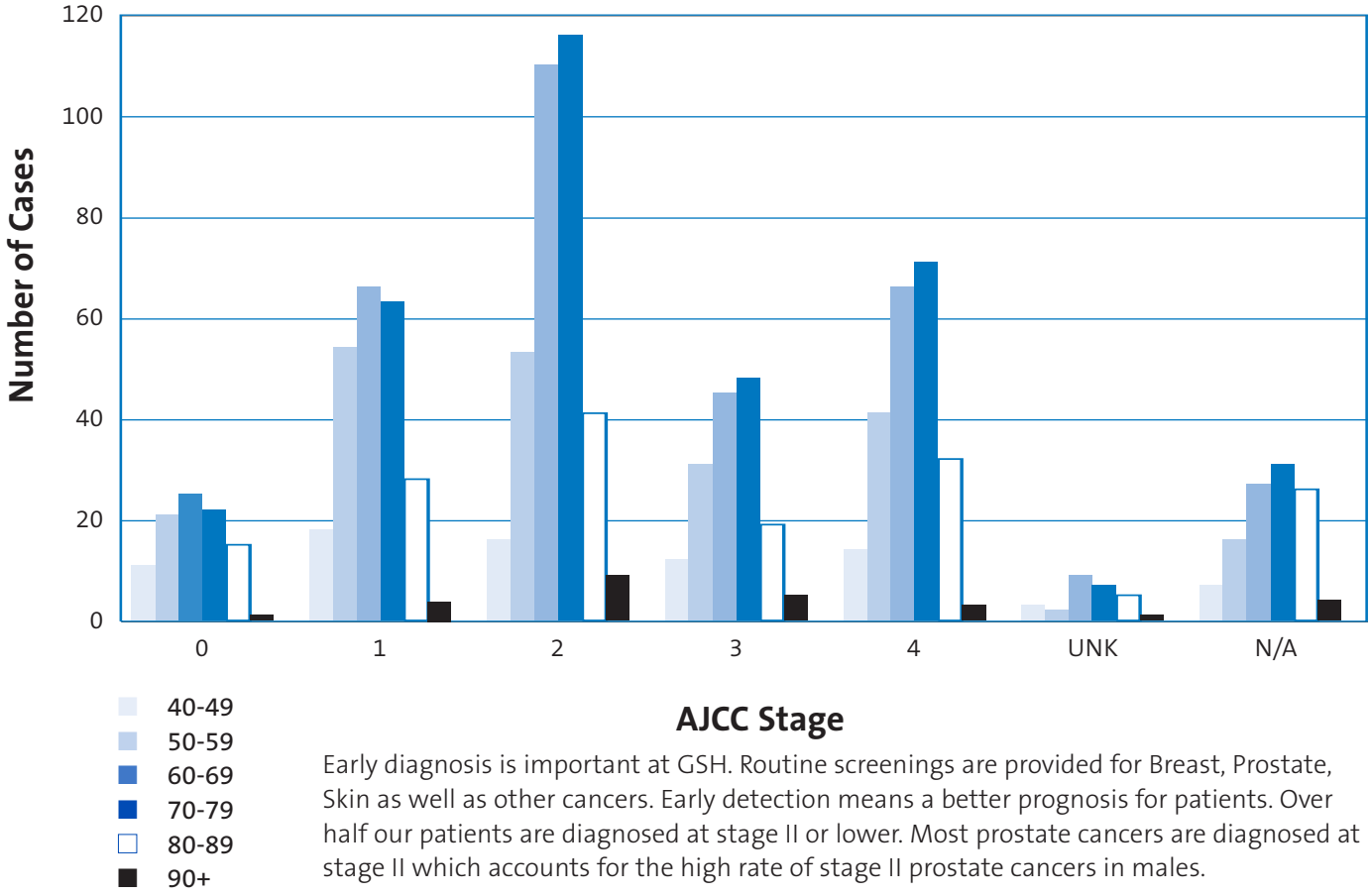
Top Five Sites by Gender

GSH			National*			GSH			National*		
Site	**Male**	**%**	**Site**	**Male**	**%**	**Site**	**Female**	**%**	**Site**	**Female**	**%**
Prostate	196	31	Prostate	186,320	25	Breast	246	40	Breast	182,460	26
Lung	119	19	Lung	114,690	15	Lung	109	18	Lung	100,330	14
Bladder	40	6	Colon	77,250	10	Colon	37	6	Colon	71,560	10
Lymphoma	37	6	Bladder	51,230	7	Uterine Corpus	33	5	Uterine Corpus	40,100	6
Colon	34	5	Non Hodgkin Lymphoma	35,450	5	Bladder/ Lymphoma	20	3	Non Hodgkin Lymphoma	30,670	4
Total male	**626**		**All sites**	**74,5180**		**Total female**	**618**		**All sites**	**692,000**	

"2008 American Cancer Society, Inc., Surveillance Research, Cancer Facts and Figures 2008"

Age at Diagnosis by AJCC Stage

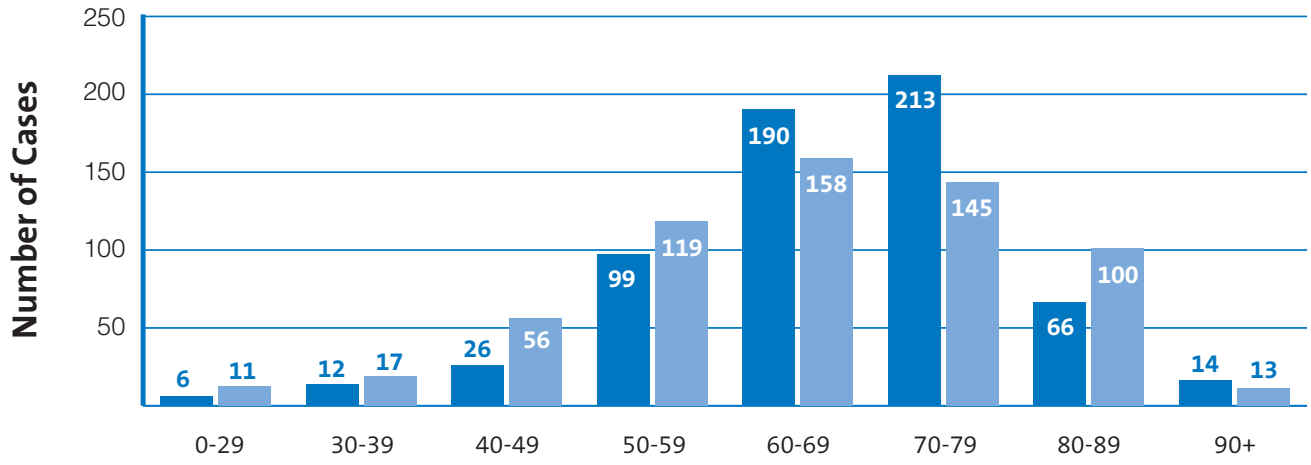
2008 Analytic Cases



Early diagnosis is important at GSH. Routine screenings are provided for Breast, Prostate, Skin as well as 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 of stage II prostate cancers in males.

Male vs Female by Age at Diagnosis

2008 Annual Report Analytic Cases

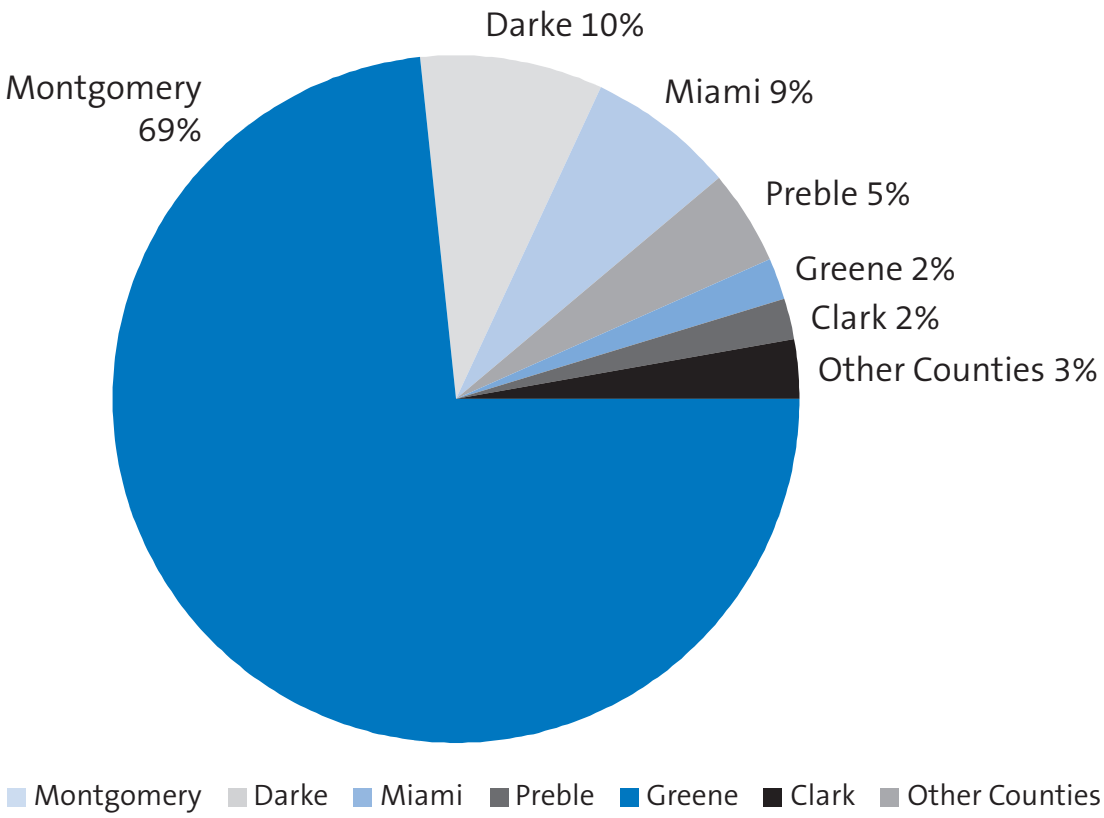


Male

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

Good Samaritan Hospital Cases by County 2008



Renal Cell Cancer Site Specific Study

Daniel P. McKellar, MD, FACS *Medical Director*

Renal cancer is a fairly uncommon cancer representing only about 2% of newly diagnosed cancers. In 2008, in Ohio there were 692 newly diagnosed cases with 222 patients dying from renal cancer. The national incidence of renal cancer is 18.3 cases per 100,000 population. The number of renal cancers treated at our institution has varied over the last few years with 35 newly diagnosed patients in 2008(figure 1). In 2007 we treated twenty-four renal cancers while in 2008 we treated thirty-five, a greater than 30% increase in one year. The average number of renal cancers treated in our institution in the last ten years was twenty-four. The reason for the significant number of cancers we treated in 2008 is unclear but may be related to new treatment options which will be discussed in this report.

The ratio of male to female patients seen at GSH showed that 60% of the patients treated were male. In comparison, the American Cancer Society (ACS) Facts and Figures showed that in Ohio, 51% of patients were male (Figure 2).

Figure 1: Renal Cancer cases treated at GSH 1999-2008

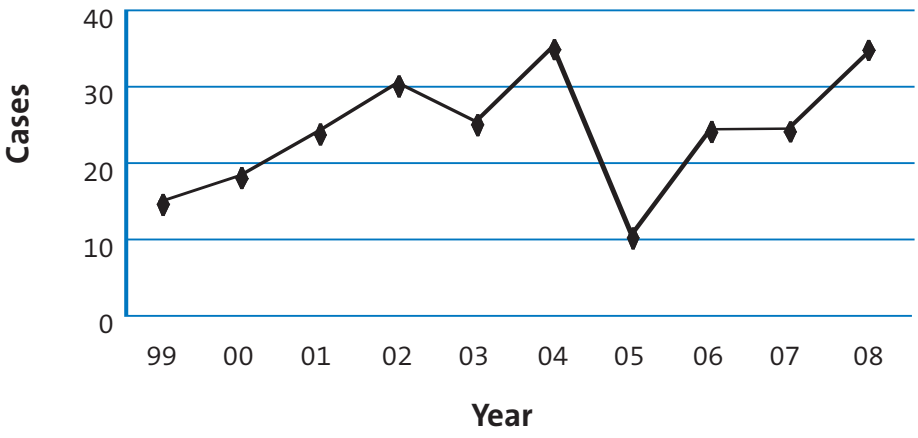
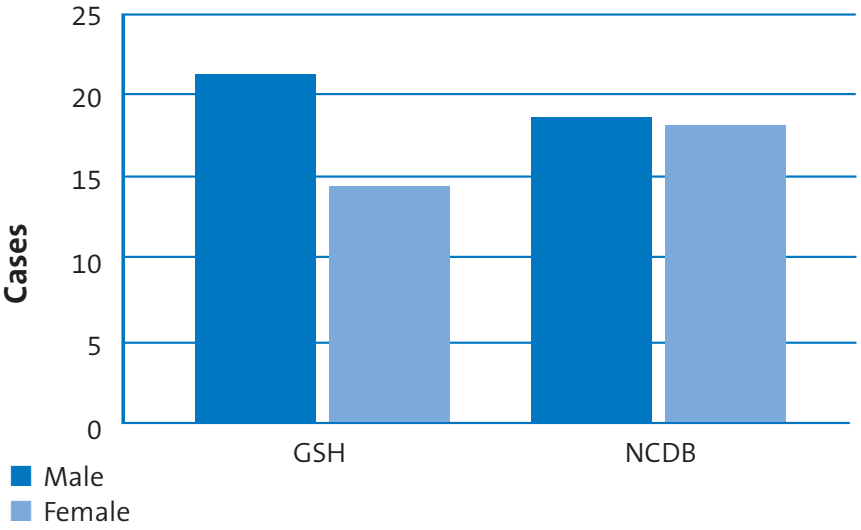


Figure 2: Male to Female ratio of renal cancers compared to NCDB



There are no early detection methods for renal cancer however many patients present at early stage due to pain, bleeding, or are found to have an abnormality on an imaging study done for various reasons. As seen in figure 3, the largest percentage of patients both at GSH and nationally are diagnosed at Stage 1.

The majority of patients with renal cancer are diagnosed between the ages of 60-80 as seen in figure 4. This compares with data from the NCDB.

Survival from renal cancer depends on many factors including stage at diagnosis, age of the patient, and treatment received. In the past the main treatment for renal cancer has been surgical resection, however, as discussed in other articles in this report many new treatments are becoming available such as radiofrequency ablation and new chemotherapy drugs. As can be seen in comparing our patients to the NCDB (figure 5) our five year survival is very similar to results from the NCDB. When we examine five year survival for all patients our survival is essentially identical to the NCDB.

In summary, our review found that our results were comparable to state and national data. Five year survival nationally as well as in our program for all patients still is only 56%. Hopefully with newer treatments as well as earlier diagnosis this will improve over the next few years. Unfortunately, there are no screening tests for renal cancer and diagnosis depends on patients presenting with symptoms or having their cancer diagnosed incidentally by imaging studies done for other reasons. At GSH we are aggressively pursuing clinical trials as well as examining and implementing new techniques with the goal of improving outcomes for patients with this cancer.

Figure 3: Stage at diagnosis of renal cancer with comparison to NCDB

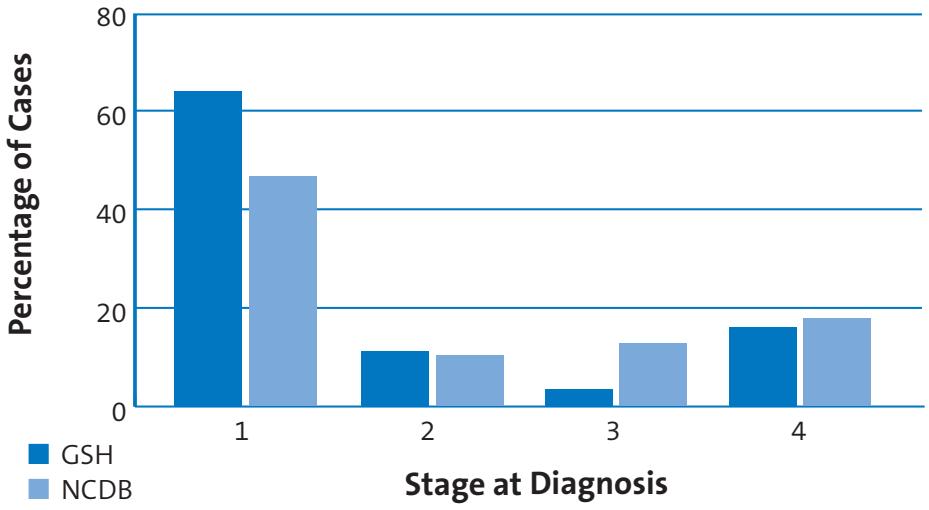


Figure 4: Age at diagnosis

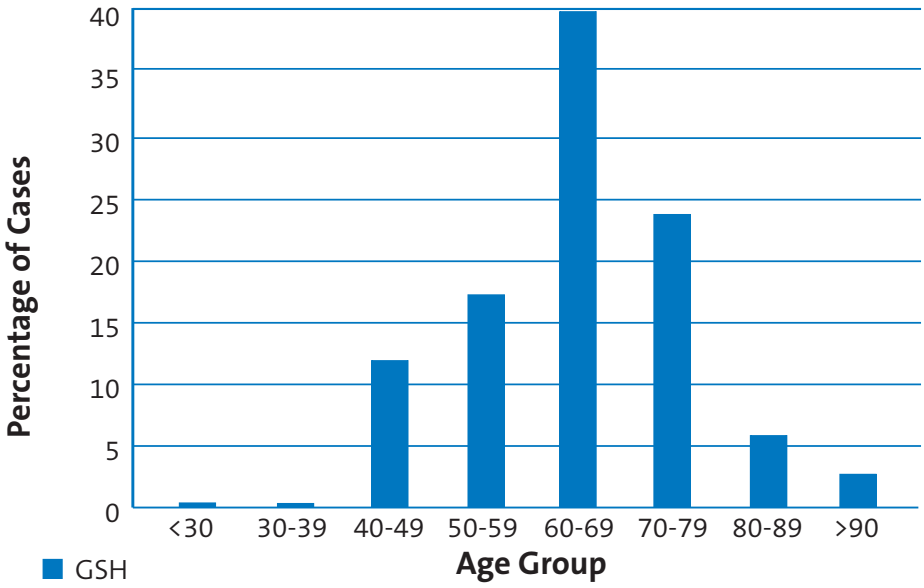
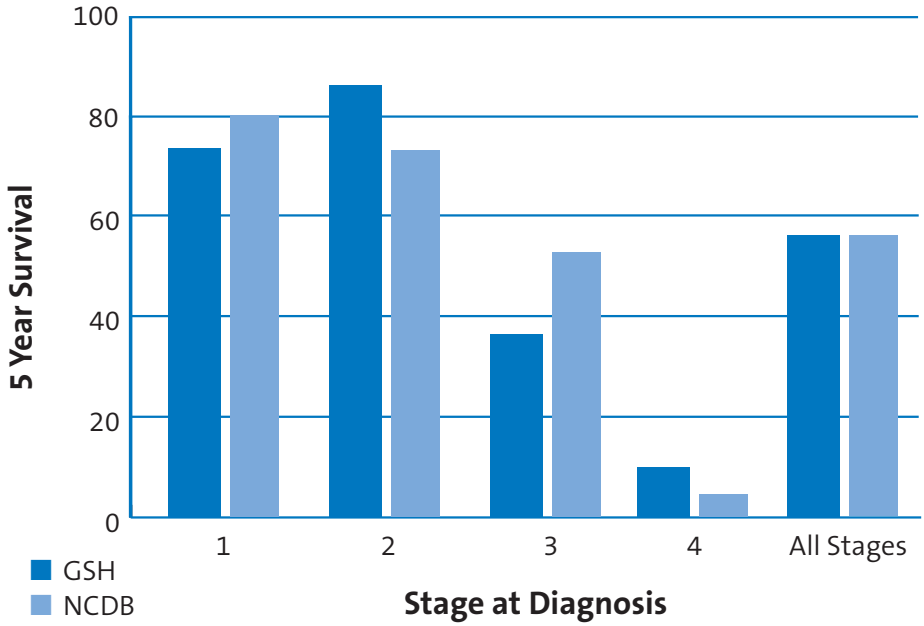


Figure 5: Five year survival by stage



Renal Cell Carcinoma Pathology

Ejaz Ahmad, MD *Pathologist*

Renal cell carcinoma is a group of malignancies arising from the epithelium of the renal tubules. Renal cell carcinoma represents about 90% of all malignancies of the kidney that occur in adults. The WHO classification of renal cell carcinoma includes:

- Familial renal cancer (von Hippel-Lindau disease, hereditary papillary renal carcinoma, hereditary leiomyomatosis, renal cell carcinoma, Brit-Hogg-Dube' syndrome).
- Clear cell renal cell carcinoma.
- Multilocular cystic renal cell carcinoma.
- Papillary renal cell carcinoma.
- Chromophobe renal cell carcinoma.
- Carcinoma of collecting duct.
- Renal medullary carcinoma.
- Renal cell carcinoma associated with Xp11.2 translocation/TFE3 gene fusion.
- Renal cell carcinoma associated with neuroblastoma.
- Mucinous tubular and spindle cell carcinoma.
- Papillary adenoma.
- Oncocytoma.
- Renal cell carcinoma, unclassified.

Most of the diagnostic criteria depend upon distinct morphology, clinical syndrome complex, and specific genetic abnormalities. Clear cell renal cell carcinoma, papillary renal cell carcinoma, chromophobe renal cell carcinoma, and oncocytoma are four major subtypes of neoplasia of the adult kidney. The papillary renal cell carcinoma has a distinct morphology of papillary structure. The rest of the three disease entities can show overlapping morophology, and in such a case, certain cytochemical and immunostains can be used for the confirmation of diagnosis. These special stains are of great help in case of small biopsies or fine needle aspiration specimens. For the special stains, several immunostains and cytochemical stains can be used for diagnostic purposes, which include carbonic anhydrase, cytokeratin 7, band 3 protein, CD 117, renal cell carcinoma (RCC) antibody, CD 10, Hale's colloidal iron, periodic acid-Schiff (PAS), and vimentin. The classic staining patterns of these major disease entities are as follows:

Clear cell renal cell carcinoma.

Hale colloidal iron negative, cytokeratin 7 positive, vimentin positive, CD 10 positive, CD 117 negative, RCC antibody positive, band 3 protein negative, and PAS positive.

Chromophobe renal cell carcinoma.

Hale colloidal iron positive, cytokeratin 7 positive, vimentin negative, CD 10 negative, CD 117 positive, RCC antibody negative, band 3 protein negative, and PAS negative.

Oncocytoma.

CD 117 positive, band 3 protein positive, carbonic anhydrase positive, RCC antibody negative, CD 10 negative, and cytokeratin 7 negative.

The role of the pathologist in identifying the exact type of renal cancer is vital as the treatment often depends on the tumor type.

Renal Cancer

Robert Tyrell, MD *Radiology Department*

Renal cancer accounts for slightly less than 2% of all adult cancers with over 200,000 cases worldwide, and with over 50,000 of these occurring in the United States. Historically, only 5% of discovered renal tumors were less than 3 cm in size, however, with the advent of cross-sectional imaging 10-40% of the renal tumors are this size or smaller with 15-48% of these lesions being found incidentally.[1] This represents a significant increase in early stage, asymptomatic renal cancer patients that has generated significant controversy over their management. Historically, nephrectomy or partial open nephrectomy has been the referenced standard; however, these methods seemed drastic in these isolated small lesions, particularly in renally impaired or more debilitated patients. This patient population has been fertile ground for the evolution of less invasive non-surgical alternatives. To this end, thermal ablation both in terms of heat deposition in radiofrequency ablation or freezing in cryoablation have recently effectively been applied to locally generate cell death and treat these lesions. As cryoablation is a relatively new technique, long-term results are limited; however, one three year[2] and a separate five year follow up study[3] report a 98% and 89.5% cancer-specific overall survival, respectively. Most studies to date are quite small, but review of needle directed ablative therapy outcomes suggests that these techniques are safe for early cancer lesions with cancer-specific survival rates similar to surgical intervention.[4, 5, 6] Much of the literature is also based on laparoscopic cryoablation although safety and efficacy of CT guided percutaneous ablation has also been shown.[7]

In summary, longer term studies are still needed, however, current data suggests a distinct role for thermal ablative techniques in the treatment of early stage renal cancers particularly in the high surgical risk group or in patients with renal impairment with current cancer-free survival rates similar to that of traditional surgery.[8]

References

1. Smith,M.A. Bosniak, A.T. Megibow "Renal cell carcinoma: earlier discovery and increased detection." Radiology, Vol. 170, No. 3, ppg 699-703.
2. Hegarty, N.J., Gill, I.S., Desai, M.M., Remer, E.M., O'Malley, C.M., Kaouk, J.H.; Probe-ablative nephron-sparing surgery: Cryoablation versus radiofrequency ablation. Urology 2006; 68 (suppl 1); F-13.
3. Davol, P.E.; Fulmer, B.R.; Rukstalis, D.B; Long-term results of cryoablation for renal cancer and complex renal masses. Urology 2006: 68 (suppl 1): 2-6.
4. Park, S.; Cadeddu, J.A.; Shingleton, W.B.; Oncologic Outcomes for Ablative Therapy of Kidney Cancer; Current Urology Reports 2007, 8:31-37.
5. Dominguer-Escrig, J.L.; Sahadevan, K.; Johnson, P.; Review Article Cryoablation for Small Renal Masses. Advances in Urology Vol. 208, Article ID 479495.
6. Okeke, Z.; Lee, B.R.; Small Renal Masses: The Case for Cryoablation, Journal of Endourology. Vol 22, No. 9, Sept, 2009; pp 1921-1923.
7. Georgiades, C.S.; Hong, K.; Bzzell, C; Gescharind, J.; Rodriguez, R.; Safety and Efficacy of CT-guided Percutaneous Cryoablation for Renal Cell Carcinoma. J.Vasc. Inter Radiol 2008; 19:1302-1310.
8. Lin, Y.; Turna, B.; Frota, R.; Aron, M.; Haber, G.; Kamai, K.; Koenig, P.; Gill, I. Laparoscopic Partial Nephrectomy versus Laparoscopic Cryoablation for Multiple Ipsilateral renal tumors. European Urology 53 (2008) 1210-1218.

Surgical Treatment of Renal Cell Carcinoma

Howard Abromowitz, MD *Urologist*

Renal cell carcinoma is the most common malignancy of the kidney and accounts for about 2% of all adult cancers. Surgery has been the standard of care for treatment since radiation therapy and chemotherapy haven't been shown to be effective. If localized at diagnosis, surgery is curative in over 85% of cases. C. Langenbuck performed the first nephrectomy for a malignant tumor in 1875 and W. Gregoire performed the first radical nephrectomy in 1903. Radical nephrectomy was introduced as the standard of care for renal cell carcinoma in 1963 by C. J. Robson, M.D. Radical nephrectomy is defined as the resection of Gerota's fascia and its entire contents including the resection of the kidney, perinephric fat, lymphatics, and the ipsilateral adrenal gland. Surgically, this can be performed through many surgical approaches including: abdominal, subcostal, flank, and thoracoabdominal.

Renal cell carcinoma is one form of cancer where surgical removal of localized metastasis is indicated. This includes the removal of isolated lymph nodes, adrenal, contralateral adrenal, liver lesions, and pulmonary lesions, as well as the removal of intracaval tumor thrombus. Intracaval tumor thrombus can extend from the renal vein to the atrium of the heart. Removal of these isolated areas of metastasis can result in up to 30% cure rate. As surgical techniques have improved, nephron sparing surgery has gained great interest. Andrew Novick, M.D. championed partial nephrectomy at the Cleveland Clinic and has proven with long term studies that it is an equally effective therapy for localized disease. Nephron sparing surgery provides both long-term cancer control and preservation of renal function. With this knowledge and experience, the development of localized tumor ablation techniques has occurred. These techniques destroy tumors as opposed to removing them, thereby preserving renal function.

Today, the emphasis has been on minimally invasive approaches. R. Clayman, M.D. performed the first laparoscopic total nephrectomy in 1990 at Washington University, St. Louis. Minimally invasive surgical approaches include: pure laparoscopy, hand assisted laparoscopic approaches, and robotic techniques with the da VinciTM system. These techniques can be used for radical nephrectomy, partial nephrectomy as well as energy ablation procedures, such as cryoablation or radiofrequency ablation, to destroy tumors in situ. The benefits of minimally invasive surgery are that it adequately manages the disease with less morbidity and quicker recovery.

The surgical treatment for renal cell carcinoma is certainly evolving. As advances

in science continue with the increasing understanding of tumor biology, improving radiographic imaging, and the continuous improvement with minimally invasive technology, the surgical approach to this disease will also continue to evolve. We, only now, understand that we do not necessarily need to remove a tumor, but we must completely destroy it. Our ability to follow a treated lesion with high quality imaging such as CT and MRI scans, allows us the flexibility to do this. If local failures occur with the less invasive procedures, these can be salvaged with more traditional surgery.

The urologist remains the quarterback in the management of care for a patient with a renal tumor. The difficulty comes in deciding the best option for the patient. However, multidisciplinary management of these tumors is vital. The decision regarding the type of initial treatment involves many factors; the size of the tumor, location of the tumor, stage of the tumor, general overall health of the patient, prior surgeries, and body habitus. It is our responsibility as surgeons to educate our patients and to recommend a treatment plan, but ultimately the well-informed patient must make the decision for a particular treatment modality.

Medical Oncology in the Treatment of Renal Cell Carcinoma

Howard Gross, MD *Medical Oncologist*

Renal Cell Carcinoma (RCC) patients with locally advanced and metastatic disease are usually not surgically curable. In addition, many patients initially resected will eventually recur. In patients with stage IV disease the prognosis is generally poor although there are clinical parameters which might support improved prognosis. These include a long interval between nephrectomy and appearance of distant metastases, a single site of metastases, and the absence of retroperitoneal adenopathy. Memorial Sloan Kettering identified five additional factors that predict shortened survival: 1) Karnofsky Performance Status less than KPS <80% 2) Lactic dehydrogenase (LDH) value greater than one and a half times the upper limits of normal 3) elevated serum calcium 4) anemia and 5) absence of nephrectomy

Historically patients with advanced Renal Cell Carcinoma have not shown very good response to traditional chemotherapeutic agents. Non-Clear Cell types may have a slightly better chance of responding. Drugs that have been used include vinblastine, fluropyrimidines, gemcitabine, and ifosfamide. Thalidomide and lenalidomide which are antiangeonenic agents have been evaluated but randomized studies show little benefit.

Immunotherapy has been used in metastatic Renal Cell Carcinoma for the past twenty years. Interferon alpha has shown response rates as high as 15% but most responses are partial and rarely persist for more than one year. High dose IL-2 can, in a minority of patients, induce complete remission which can be curable. The toxicity of such treatment can be great and usually reserved for patients with good prognostic disease and excellent overall performance status.

Recent major advances in treatment have been with Molecularly Targeted Therapies. Vascular Endothelial Growth Factor(VEGF) pathway inhibitors which affect tumor angiogenesis have become a popular and successful target for this biological therapy. Two small molecule Tyrosine Kinase Inhibitors, Sunitinib and Sorafenib have been approved for first line treatment, with doubling of progression free survival (PFS).

Bevacizumab is a monoclonal antibody that directly binds to VEGF. This drug has been approved to be used in combination with interferon alpha.

Two inhibitors of the mTor pathway have shown clinical activity in patients with poor prognosis advanced Renal Cell Carcinoma. Tensirolumis is being used as a parenteral single agent and Everolimus is the most recently approved drug. It is an oral agent currently being used in patients who have failed VEGF inhibitors.

Currently, research is ongoing and looking at new targeted agents as well as combinations of drugs.

Historically adjuvant chemotherapy or immunotherapy has failed to show improvement in PFS or overall survival in less advanced disease although ongoing trials with targeted agents are currently taking place.

Radiation's Role in Renal Cell Carcinoma

Gregory Rasp, MD *Radiation Oncologist*

Renal cell carcinomas are predominantly treated with surgery and systemic therapy. In general, radiation therapy does not play a prominent role in the treatment of patients with this disease. Despite that, at Samaritan Cancer Center, we use the latest radiation technologies to treat difficult palliative situations for patients with renal cell carcinoma. For example, intensity-modulated radiation therapy (IMRT) and image-guided radiation therapy (IGRT) are used to treat metastasis in delicate areas of the body where adjacent normal tissues cannot tolerate high does of radiation therapy. Additionally, stereotactic radiation therapy (SRT) can be used to treat solitary brain metastasis.

As with all cancers treated at Samaritan Cancer Center, a dedicated team of physicians representing the diverse spectrum of specialties work together to give the patient optimal care using the latest technologies available.

Clinical Trials

Howard Gross, MD *Medical Oncologist*

The majority of Good Samaritan Hospital physicians who treat cancer patients participate in clinical trials through the Dayton Clinical Oncology Program (DCOP) either as referring or treating physicians. DCOP celebrated its 25th anniversary in 2008 as one of approximately fifty community oncology programs in the United States. Cancer control and prevention trials are available in addition to treatment trials for most of the major types of cancer. The trials are available through several national research bases as well as the Clinical Trials Support Unit (CTSU) which is directly administered by the NCI. There are currently fifteen member institutions that support DCOP, including hospitals in Indianapolis, Indiana and Findlay, Ohio. 220 patients were accrued to treatment and cancer control trials by DCOP physicians in 2008. Three of the top four accruing physicians were GSH based physicians. Howard Gross MD continues as the Principle Investigator of DCOP. Katherine Peyton, RN and Eileen Flynn, RN are the current Oncology Research Nurses serving Good Samaritan Hospital and Good Samaritan North Health Center.

DCOP currently has four different Renal Cell Cancer protocols available for various stages of the disease. To have a patient evaluated for study or if you have questions about DCOP call the DCOP office at (937) 395-8678 or contact one of the research nurses at (937) 279-5847.

Genetics of Renal Cancer
The Cancer Genetics Program

Faith Callif-Daley, MS, CGC *Certified Genetic Counselor*

There is a hereditary subset of cancer of the kidney which is often identifiable by its departure from the norm. Hereditary susceptibility to renal cancer should be suspected in patients with bilateral or multiple primary renal cancer, rare tumor types, early age of onset, and/or positive family history.

There are several hereditary renal cancer syndromes, identifiable by their unique combination of family history, cancer pathology, and associated clinical characteristics. The table below summarizes the clinical features of these syndromes. For each one of these conditions, valid DNA testing is available. Hereditary renal cancers are a relative rarity but are important to identify for the purposes of future cancer prevention in the patient and family members and possibly to alter cancer treatment. Each one of these syndromes has autosomal dominant inheritance placing many close relatives at 50% risk for the condition. Affected patients and their at-risk relatives should be screened more aggressively for additional renal or related conditions if any of the above syndromes were present. Surgical treatment considerations may be altered by the potential for bilateral or multifocal disease and progress is being made toward gene specific treatments in each of the above syndromes.

Physicians can refer patients with personal or family history of renal cancer for genetic counseling or genetic testing by calling The Cancer Genetics Program, a combined program of Good Samaritan Hospital and Dayton Children's Medical Center, at (937) 641-3800.

Gene	Condition	Type of renal cancer	Other associated features
VHL	Von Hippel Lindau	Renal cell carcinoma (clear cell)	Renal cysts Pheochromocytoma Pancreatic cysts Hemangioblastoma of brain and spine
MET/HPRC	Hereditary Papillary Renal Carcinoma	Type 1 Papillary renal cancer	None
BHD	Birt Hogg Dube	Chromophobe Hybrid Oncocytic Clear cell RCC	Fibrofolliculoma Pulmonary cysts Spontaneous pneumothorax
FH (fumarate hydratase)	Hereditary Leiomyomatosis Renal Cell Carcinoma	Aggressive with early metastasis Similar to type 2 Papillary renal ca or collecting duct RCC	Cutaneous leiomyomas Uterine leiomyomas Leiomyocarcoma (rare)
TSC1 TSC2	Tuberous Sclerosis	Renal cell carcinoma	Renal angiomyolipoma Distinctive skin abnormalities Distinctive brain abnormalities Heart rhabdomyomas

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 2008 were:

- 100% of patients who undergo thoracotomy will have preoperative evaluation per NCCN guidelines.
- Adequate mediastinal lymph node sampling will be maintained at 80%.
- 60% of all new lung cancer cases will be presented at lung conference.
- Within three months and prior to surgical resection, 100% of patients will undergo pulmonary function testing.

In 2009, we maintained the same goals with the addition of a fifth one:

Analyze the first half of 2009 cases to determine the percentage of patients with an interval greater than 20 days between positive path (tissue diagnosis) and the first treatment. Plan and /or implement a strategy based on study outcomes 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 for 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 reviewing 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, chemotherapy, and targeted therapies.

Breast Cancer Program

Thomas Heck, M.D., FACS *Medical Director*
Ann Lensch, RN, BSN, MS *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).

In 2008 the Breast Cancer Program prepared for the renewal of our Joint Commission Program Certification which was first awarded in May, 2007. Good Samaritan Hospital was the first in the nation to receive this certification for breast cancer care. The program leaders also prepared for the new Breast Center Certification through the American College of Surgeons' National Accreditation Program for Breast Centers (NAPBC). The disease specific certification renewal was achieved as well as accreditation by the NAPBC in May, 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 expectations for their future.

In 2008, the Samaritan Breast Center broadened its role as an imaging center to a more comprehensive center where a surgeon specializing in breast diseases, sees patients. The surgeon performs ultrasound 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.

The Samaritan Cancer Center is the recipient of a grant 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.

This grant iis funded through the sale of a special breast cancer license plate. (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, classrooms A&B, 6:00-8:00 pm. 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.

Some of the topics in 2008 included:	
Subject	**Presenter**
Healthy Eating	Susan Knapke, RD
Relaxation Techniques	Dr. Indermohan Sandhu, Oncology Fellow
Dealing with the Effects of Chemotherapy	Joyce Marrs, MS, APRN-BC, AOCNP
Melanoma Update	Diane Tousignant, RN, BSN Melanoma Coordinator
Survivors Present to the Physicians	Breast Cancer Survivors

High Risk Breast Cancer Program

In 2008 the first High Risk Breast Cancer Program in the Dayton, Ohio area was developed at Good Samaritan North Health Center. 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.

Multidisciplinary Melanoma Program

Diane Tousignant, RN, BSN *Melanoma Program Coordinator*

The Multidisciplinary Melanoma Program is Good Samaritan Hospital's newest multidisciplinary coordinated program 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 nurses, 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 returns 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 in collaboration with Wright State University. We look forward to having a positive impact on our community and welcome the challenge of caring for melanoma patients in Montgomery County and our surrounding northern counties.

Medical Oncology/ Infusion Services

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

The Medical Oncology/Infusion Services area of our Cancer Center provides care for patients receiving chemotherapy, blood transfusions, other IV medications and minor procedures on an outpatient basis. Collaboration between our Inpatient Oncology Unit 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, and—with referral—home care services including Hospice, physical therapists, and psychologists. In May of 2009, Infusion Services extended hours into the evening three nights per week n order to accommodate additional patients.

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

In 2008 and continuing into 2009 through the efforts of the Infusion staff, Pharmacists and playing a lead role, our Oncology Social Worker, we were able to receive more than three hundred thousand dollars in free drug replacement for our patients.

Radiation Oncology

Gregory Rasp, MD *Medical Director, Radiation Oncology*

This year marks another successful year in Radiation Oncology at Good Samaritan Hospital. Our state of the art facility and cutting edge technologies have created a dramatic increase in patient volumes. As our physicians gained experience with IMRT, we have been able to expand the horizons for the technology to include more and more disease sites.

Image guided radiotherapy has shown a significant improvement in the tolerance to radiation therapy for our patients. Complication rates are down across the board. White it takes many years to develop adequate follow up of our patients to make conclusions regarding cure rates, to date we have seen early promising signs of improvement.

In 2009 our department completed its integration with medical oncology. We implemented the installation and commissioning of a PET/CT scanner within the department. This allows for extremely accurate location of tumors prior to beginning radiotherapy. Additionally we installed a new linear accelerator with expanded capabilities. This machine is more accurate than the older model it replaced and also allows for more rapid treatment of a patient. The time the patient has to lay on the table has been reduced significantly with this advance.

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.

Support Services in the Samaritan Cancer Center

Bobbie Martin, RN, MS *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 7:30 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 female cancer patients 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 knowledge, understanding of the process for receiving radiation therapy and support.

Patients and their families receive a tour of the facility, including especially the radiation treatment area. The program is held every Tuesday evening starting at 4:00 p.m. in the Samaritan Cancer Center. Patients and their families are welcome to attend. It is a time for them to ask questions and see the machine on which their loved one will be treated, and ask questions.

Oncology In-Patient Unit

Melissa Armstrong, RN, BSN *Nurse Manager*

The Inpatient Oncology Unit 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, dieticians, 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. The oncology unit is comprised of thirteen private patient rooms. Two of the patient rooms have special air-flow systems designed to meet the needs of immunocompromised patients.

The specialized staff of the Oncology In-Patient Unit ensures that the hospitalized oncology patient and their family are provided with the necessary education and resources to continue their treatment in the out-patient setting. 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.

Palliative Care Program

Melissa Armstrong, RN, BSN, *Palliative Care Program Coordinator*

Palliative Care is a philosophy aimed at relieving suffering and improving the quality of life for patients with advanced illness and their families. It is offered simultaneously with all other appropriate medical treatment. 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. Palliative care programs are increasing in the United States to address the growing number of people with complex advanced illness. These programs strive to fulfill the ethical, demographic, clinical, regulatory, educational and financial imperatives required to provide the comprehensive services our patients and their families need and deserve.

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 physician, nurse, pharmacy/pain management, pastoral care and integrated care (social worker/case manager). The goals of this 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:

- **Dr. Charles Bane, Medical Oncologist**
  Certified Palliative Care Medical Director
- **Betty Love, RN, MS**
  Director of Palliative Care, the Oncology In-Patient Unit and Critical Care
- **Josh Cox, Pharm D., BCPS**
  Pain Management Consultant
- **Melissa Armstrong, RN, BSN**
  Manager of Palliative Care and the Oncology In-Patient Unit
- **Carole Smith, RN, MS, CCRN**
  Pain Management/Palliative Care CNS
- **Sr. Rosemary Goubeaux, CPPS**
  Pastoral Care Services

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

Oncology Social Worker

Constance Ickes, LISW

As the Oncology Social Worker, I am available in the Samaritan Cancer Center to assist cancer survivors and their families with psychosocial issues. 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, and education about support groups. When patients and families cannot afford their medications, I assist the patient in accessing local community programs and have been very successful in working with the pharmaceutical assistance programs to obtain free drug replacements. In 2009 this program and the process involved was shared with the other PHP member hospitals.

Renal Cell Carcinoma and Nutrition

Martha K. Grodrian RD, LD, CDE

Nutrition provides underlying support for human life. Nutritional support for individuals with renal cell carcinoma can:

- Prepare the patient for surgery and for post surgical wound healing.
- Control nutrition-related side effects of radiotherapy and chemotherapy
- Control hypertension
- Correct anemia (a common side effect)
- Maintain adequate hydration
- Minimize weight loss and promote weight maintenance
- Promote adequate bowel function
- Maximize food intake through side-effects management and anticipatory guidance.

Specific food and nutrition interventions can:

- Increase intake of protein, carbohydrate, energy, iron, B-vitamins, and fluids to meet needs.
- Alter the diet as appropriate for side effects of cancer therapies.
- Encourage small, frequent meals to help keep weight stable.
- Promote adequate vitamin/mineral intake from diet and supplements if physician recommends.

Nutrition support education for those with renal cell carcinoma focuses on meeting nutrition needs in the context of family support, patient ability and desire to eat, as well as therapeutic interventions. Comfort measures and nutritional strategies to deal with side effects of therapy (e.g. taste aversions, constipation, diarrhea, dry mouth, early satiety, etc.) are offered as part of nutrition therapy.

The patient is encouraged to eat a protective diet by including at least five servings per day of fruits and vegetables (especially root vegetables like carrots and beets). Weight reduction, if overweight, is appropriate after cancer therapy has finished.

- Suggest curcumin as a seasoning if tolerated
- Include more Omega-3 fatty acids from fish, shellfish, flaxseed, and walnuts.

Patients are counseled to avoid herbs and botanical supplements unless the physician approves, since many herbs may be contaminated with heavy metals such as mercury or may contain potassium, which may harm the kidney. A prudent intake of sodium will help decrease risk of and/or control hypertension (2-3 gm sodium per day.)

After a diagnosis of cancer, a patient is encouraged to consult with a registered dietitian. Preventive problem solving can optimize nutrition status, decrease anxiety over what and how to eat, individualize meal planning to consider other medical problems that a patient may have, 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 quality care to the patient.

Community Outreach: Premier Community Health

Pamela M. Reichel, MS, CPW, CHES

On behalf of Good Samaritan Hospital, Premier Community Health (PCH) offers community health programs focusing on prevention, early detection and disease self-management of 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 2008, the program provided:

947 mammograms, finding 15 cancers

757 Pap tests, finding 7 cancers

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

While Caucasian women get breast cancer more, African American women die more than any other group from this devastating disease. In 2008, My Sister's Keeper began with grants from the Avon Foundation and the Susan G. Komen Fund for a Cure, Cincinnati Affiliate. 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 2008, My Sister's Keeper served 1,032 women at 71 parties. Of these 843 agreed to get a mammogram. Of those, 155 had the first mammogram of their lives- and one had cancer.

In 2008, MSK received the Aesculapius Award of Merit, a national health communications award.

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 Premier Community Health, Good Samaritan Hospital, Miami Valley Hospital, Atrium Medical Center, WDTN-TV2, Kroger pharmacies, the National Cancer Institute's Cancer Information Service, and Vectren. Test for Life distributed free fecal occult blood test kits to more than 15,000 people in 2008. Of those, 12.7% returned a results card, finding 4 cancers.

The Test for Life was presented at a poster session at the American Public Health Association National Meeting in San Diego, California in 2008. Also in 2008, Test for Life received a Merit Award from Healthcare Marketing Report Awards and the Aster Awards for Excellence in Healthcare Marketing. It was also named an Ohio Model Program by the Ohio Partners for Cancer Control.

Skin Cancer

Each May, Good Samaritan Hospital collaborates with the Wright State University Boonshoft School of Medicine's Department of Dermatology, the National Cancer Institute's Cancer Information Service, and Kettering Medical Center to offer free skin screenings at locations throughout the area. In 2008, 1,146 people were screened at eight locations, finding two basal cell cancers, three squamous cell cancers and two melanomas.

Prostate Cancer Screening

Good Samaritan Hospital and other Premier Health Partners hospitals offer prostate screening each September. Men age 50 and older (45 if African American) can receive a free PSA blood test and a digital rectal exam (DRE) performed by a physician. In 2008, 98 men obtained screening at Good Samaritan Hospital.

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. Premier Community Health offers the services of a certified smoking cessation counselor free of charge.

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
The High Risk Breast Cancer Program
Breast Care Coordinator
Lung Cancer Coordinator
Oncology Rehab
Oncology Social Services
Oncology Data Services
Pastoral Care
Cancer Support Groups
Camp Samaritan

Good Samaritan Hospital
Premier Health Partners

Samaritan Cancer Center
Good Samaritan North Health Center
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Dayton, Ohio 45415
(937) 279-5800

GoodSamDayton.org

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