



THE CANCER INSTITUTE AT ST. JOSEPH MEDICAL CENTER

2011 ANNUAL REPORT | 2010 STATISTICS



A NEW DAY IN CANCER TREATMENT

WELCOME

FROM THE INTERIM MEDICAL DIRECTOR

MICHAEL SCHULTZ, MD



As the Cancer Institute at St. Joseph Medical Center celebrates its fifth anniversary, I am pleased to report that we are a strong and vibrant comprehensive cancer center. We have accomplished a great deal in a few short years, and this year has been no exception.

Dr. Yousuf Gaffar, a respected and accomplished hematologist/oncologist, joined our center early in 2011. He has been an outstanding addition to our team, allowing us to expand our hematology service line while providing expertise for our medical oncology patients as well. He joins Dr. Richard Schraeder in the diagnosis and treatment of hematologic disorders, leukemias, both Hodgkin's and non-Hodgkin's lymphomas, as well as multiple myeloma, and myelodysplastic syndrome (MDS). Both Dr. Gaffar and Dr. Schraeder are board certified in hematology, which also encompasses benign conditions such as bleeding disorders and various blood component abnormalities. Clinical trials are available to further advance the care of these conditions.

This year also marked the establishment of an enhanced inpatient oncology unit. This state-of-the-art unit will provide the highest levels of care for hospitalized oncology patients in 20 specially designed rooms with full private facilities, in a truly comfortable setting. Through an extensive series of fundraising events led by the St. Joseph Medical Center Foundation, as well as major funding by St. Joseph's Board of Directors, construction will begin in early 2012 and is due to be completed within six months. An extensive planning process involving all hospital departments, physicians, and nurses has allowed for input and expertise

ensuring that the unit will be a superior addition to our ability to care for cancer patients who require hospitalization.

The Cancer Institute continues to actively pursue grants that allow us to further our mission. As in prior years, we have received funding from many sources, including a unique grant from the American Cancer Society (ACS) South Atlantic Division. St. Joseph provided a \$50,000 matching grant, bringing the total funds provided to \$100,000. This very special project, called "One Voice," supports a focused, culturally sensitive outreach program, which continues and expands the long tradition of the Breast Center to provide care to the underserved and at-risk minority populations in our community.

One Voice establishes a collaborative effort between the Breast Center at St. Joseph and the American Cancer Society along with Sisters Network Baltimore Metropolitan and Nueva Vida. The purpose of this program is to empower underserved women to speak out with one voice in understanding their own breast health and in gaining access to routine breast screening and treatment for breast cancer. Although African-American and Latina women have always been part of St. Joseph's focus for diagnostic as well as pro-active cancer care, this grant will allow for the education of the underserved, provide free screening mammograms through a partnership with Advanced Radiology, provide patient navigation services to women who develop breast cancer, and overall, save more lives.

Another American Cancer Society grant enabled Brandon Costantino to join our staff as a patient resource navigator. His role is to focus on assisting patients and their caregivers with non-medical needs, including transportation and financial assistance. He enables patients and families to obtain much-needed resources from the greater hospital community, the ACS, and outside organizations.

Our "Survivors Offering Support" initiative provided by a grant from Susan G. Komen for the Cure®, as well as Cancer Institute funds, is another wonderful and unique feature of the Breast Center, allowing patient survivors of breast cancer to meet with and mentor our breast cancer patients. They provide much needed guidance, support, and care.

Other grants received this year have allowed the Cancer Institute to continue to host additional screenings, including two for cervical cancer in which 75 underserved women were evaluated.

In July, we participated in Catholic Health Initiatives' (CHI) annual National Oncology Service Line Conference held at Memorial Hospital in Chattanooga. Robin Cohen, practice manager at the Breast Center, presented a best practice profile, "Preparing for the NAPBC Breast Center Survey." Dr. Randy Tabb of our practice partner Advanced Radiology reviewed "The Critical Role of the Breast Radiologist," and I was privileged to present our service-trademarked paradigm of care, "No More Sleepless NightsSM." We were all very well received by more than 200 participants at the conference.

In November, we implemented Varian ARIA, an oncology-specific electronic health record (OEHR). The successful introduction of this project was due, in large part, to an incredible team effort by our staff members over many months time. ARIA provides a number of oncology-specific benefits including strong data integration and clinical information that will improve patient care and help us maintain a strong position in cancer care. ARIA will help us meet many objectives of the CHI Oncology Service Line, including the development of a St. Joseph national quality



outcomes scorecard, cancer treatment summaries, survivorship care plans, tracking, and follow-up of nurse navigated patients, patient research study calendars and clinical protocol alerts for clinical research studies, chemotherapy safety measures, and much more.

ARIA will provide all members of the health care team with the same detailed clinical information, allowing for continuity of care and improved safety and quality of care. It will ensure that we are at the forefront of electronic medical record keeping for our oncology patients and for the CHI community at large.

As we embark upon the adoption of CHI's National Oncology Service Line's strategies for 2012, we will focus on the four pillars of "people, quality, stewardship, and growth." These will include expansion of resources to ensure optimal participation and leadership for oncology across CHI facilities, examining the impact of patient navigation, clinical pathways, cancer registry optimization which includes standardization of a CHI national registry model, multidisciplinary programs, and clinical research.

Finally, fulfilling the dual roles of medical director of the Breast Center, as well as the interim medical director of the Cancer Institute has been a bit challenging. However, it is most rewarding given the wonderful center we have become. I would like to publically acknowledge the wonderful assistance of the entire staff of the Cancer Institute and members of St. Joseph Medical Center.

COMMISSION ON

FROM THE CANCER LIAISON PHYSICIAN

STEPHEN RONSON, MD

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The Commission on Cancer (CoC) is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive quality care.

Cancer Liaison Physicians (CLPs) are volunteer physicians responsible for providing the leadership and direction to establish, maintain, and support their facility's cancer program. Charged

with the task of spearheading CoC activities at the facility and community level, CLPs are a required component of CoC-approved cancer programs and serve a 3-year term with eligibility to serve an unlimited number of terms.

The Cancer Institute at St. Joseph Medical Center has again achieved accreditation with commendation by the American College of Surgeons Commission on Cancer (CoC). This accreditation is for a 3-year term and we will have our next survey in 2014. The Cancer Institute received commendations in the following categories:

- Standard 2.11 Outcomes Analysis – Annual Report of cancer program activity, published yearly by the cancer committee, includes an outcome analysis.

- Standard 3.7 NCDB (resubmission) of Quality Criteria – For every year between surveys, cases diagnosed in 2003 or more recently meet the quality criteria for the annual call for data on initial submission.
- Standard 4.6 CAP Guidelines – 2008 pathology reports did not consistently have synoptic reporting; in 2009 it was 100%.
- Standard 5.2 Clinical Trial Accrual – The commendation percentage of cases for this category is accrued to cancer-related clinical trials.
- Standard 6.2 Prevention and Early Detection – Three or more prevention or early detection programs are offered each year, either on-site or coordinated with other facilities or local agencies.
- Standard 8.2 Cancer-related Quality Improvements – More than two improvements that directly affect cancer patient care are implemented and documented each year.

Many of the standards used by the CoC to evaluate a Cancer Institute have been revised in the past year. These changes are scheduled to be put into effect during the next three years. The rationale behind revising many of the standards was to make the standards more practical and more focused on quality patient care. These revisions raise the bar for hospitals to achieve accreditation. Here at the Cancer Institute at St. Joseph Medical Center, I am proud to say that we already meet the

CANCER

requirements of many of the new standards and have been for quite some time. I believe this is reflective of our commitment to provide the highest possible quality of care to our patients.

The Cancer Institute continues to be at the forefront of technology and cutting edge treatment techniques. We are implementing the ARIA Oncology Electronic Medical Record which will improve communication between specialists and allow for instant access to clinical notes, laboratory results, and vital signs at any location within the department. In my department of Radiation Oncology, we are in the midst of commissioning our new Varian TrueBeam Linear Accelerator. The TrueBeam will allow us to deliver the most sophisticated forms of radiation therapy in the safest possible way. Treatments will be quicker and more precise than any other treatment machine being used in the region. Finally, I am proud to say that the Cancer Institute currently has 26 clinical trials open for our patients for a variety of forms of cancer. The clinical trials allow us to offer patients access to the newest forms of treatment that are being studied nationwide.

I look forward to another year of providing the highest quality care for our patients and striving to improve this quality by meeting all of the new standards of the CoC, introducing new cutting edge technologies, and even more clinical trials.

Dr. Ronson and his daughter with fellow St. Joseph employees at the 2011 Annual Cancer Survivors Day Celebration at Camden Yards.



ACTIVITY

CANCER INSTITUTE REGISTRY ACTIVITY

DATA ANALYSIS

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St. Joseph Medical Center (SJMC) began collecting cancer data for its American College of Surgeons Commission on Cancer (ACoS-CoC) approved cancer registry starting with patients diagnosed January 1, 1997. The cancer registry now serves as a cancer data repository for more than 16,000 cancer cases. Under the direction of SJMC Cancer Institute leadership, certified cancer data management professionals, known as certified tumor registrars (CTRS), collect data on patient demographics, primary tumor site, tumor histology, cancer stage at diagnosis, and all first course treatment modalities for all patients diagnosed and receiving all or a portion of their first course treatment

at the Cancer Institute. These patients receive lifetime annual follow-up to assess for survival and for disease status when this information is available. Registry data are collected and analyzed in accordance with the standardized cancer data collection rules set forth by the ACoS-CoC and the Maryland Cancer Registry (MCR). SJMC clinicians use cancer registry data to assess clinical outcomes, measure the institution's cancer prevalence, and employ cancer registry data as source documentation for research projects. The Cancer Institute has also elected to collect data for patients being treated at the facility for a recurrence or progression of a cancer that was previously diagnosed

2010 FIVE MOST FREQUENT CANCER SITES AT ST. JOSEPH MEDICAL CENTER STAGE AT DIAGNOSIS

		Breast	Prostate	Lung	Colorectal	Melanoma	
American Joint College of Surgeons (AJCC) Cancer Stage	Stage 0	23.4%	0.0%	0.0%	10.9%	27.1%	Stage 0 – Carcinoma in situ – an early form of carcinoma
	Stage I	41.2%	7.8%	29.1%	24.8%	61.4%	Stage I – Localized to one part of the body
	Stage II	24.7%	85.0%	10.5%	28.7%	6.0%	Stage II – Involves regional lymph nodes
	Stage III	7.8%	4.2%	20.2%	21.8%	1.0%	Stage III – Locally advanced
	Stage IV	2.6%	3.0%	38.8%	11.9%	3.0%	Stage IV – Metastasized or spread to other organs throughout the body
	Not Staged	0.0%	0.1%	.007%	2.0%	1.0%	

Source: St. Joseph Cancer Institute Registry

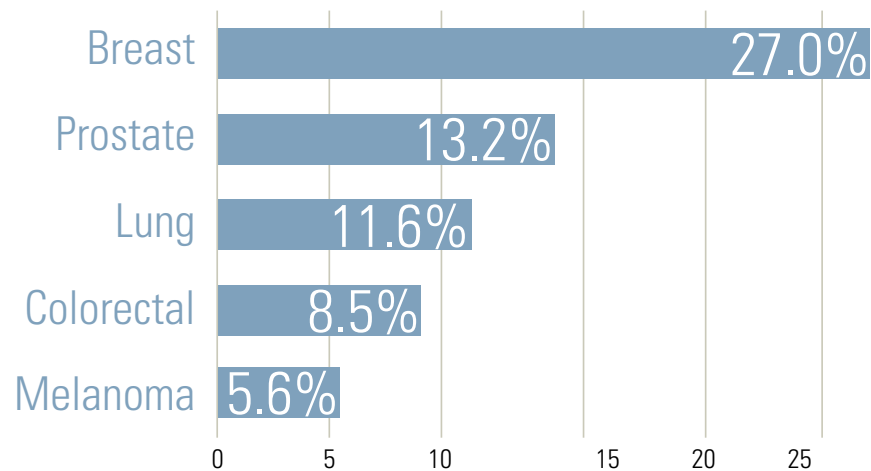
“Everyone we had contact with in the Cancer Institute from the receptionist, nurses, aides, technicians, and doctors to social workers were knowledgeable, loving, and patient.”

∞ C.S.



and received all first course treatment outside the institution. In strict compliance with the Federal Health Insurance Portability and Accountability Act, SJMC cancer registry data are reported to a variety of external entities, including the ACoS-CoC’s National Cancer Data Base (NCDB), the MCR, the North American Association of Central Cancer Registries (NAACCR), and the Centers for Disease Control National Program of Cancer Registries (CDC-NPCR). These data are used to measure cancer incidence and are ultimately used to assist public health professionals in designing early screening and cancer prevention programs. The Cancer Institute is a proud participant in the National Cancer Institute Community Cancer Centers Program and has adopted the ACoS-CoC’s Rapid Quality Reporting System (RQRS) Pilot Program as a part of its quality of care pillar. SJMC cancer registry data are utilized as source documentation to support these efforts, as well as other national and local research projects. All patient information in the registry, as always, is strictly confidential and secured.

2010 FIVE MOST FREQUENT CANCER SITES DIAGNOSED AT ST. JOSEPH MEDICAL CENTER



Source: St. Joseph Cancer Institute Registry



“The staff at St. Joseph are all wonderful, caring people, and I thank you for taking care of me...my getting well is as much from your care as from the medicine you administer. My words can never really convey how much you all helped me.” ∞ E.H.

CANCER INSTITUTE REGISTRY ACTIVITY

DATA ANALYSIS

The ability to retrieve timely, reliable cancer registry data is an important objective of the SJMC cancer program. The medical staff routinely review cancer registry data to ensure its quality and validity, and cancer registrars are required to participate in continuing education activities via a variety of media and venues. A fourth full time seasoned cancer registrar joined the staff in 2010. Expansion of the staff facilitated the achievement of concurrent abstracting. The registry is now abstracting cases six to eight weeks from the patient’s date of first contact. For the 2010 data year, the SJMC cancer registry staff added an additional thirteen hundred and eighty-six (1,386) cases to its data base. Twelve hundred and seventy-seven (1,277) cases were either diagnosed at the facility or diagnosed and received all or a portion of their first course treatment at SJMC. One hundred and nine patients (109) received treatment at SJMC for a disease recurrence or progression. The registry staff also registered and reported to the Maryland Cancer Registry one hundred and seventy-eight (178) laboratory-only cases. Laboratory-only cases are patients that have their cancer diagnosis pathologically or cytologically confirmed initially by SJMC pathology services, but the patients never physically present to the institution. In addition to cancer case registration, all cancer registry staff participated in activities to maintain annual patient follow-up rates in compliance with ACoS-CoC standards.

2010 PRIMARY SITE TABLE

Primary Cancer Site	Analytic* Cases	Non-Analytic** Cases	Male	Female	Total 2010 Cases
Breast	345	41	3	342	386
Prostate	168	4	168	0	172
Lung	149	11	55	94	160
Colorectal	108	17	63	45	125
Melanoma	70	3	34	36	73
Pancreas	60	2	31	29	62
Bladder	41	7	27	14	48
Lymphoma	33	0	21	12	33
Hematopoietic	32	5	19	13	37
Corpus Uteri	31	1	0	31	32
Kidney/Renal Pelvis	29	2	16	13	31
Brain/Other CNS	28	0	6	22	28
Unknown Primary	22	3	17	5	25
Stomach	20	0	12	8	20
Esophagus	18	0	14	4	18
Liver- Intrahepatic Bile Duct	17	2	11	6	19
Small Intestine	9	1	2	7	10
Cervix	8	1	0	8	9
Anus	7	1	2	5	8
Thyroid Gland	6	0	3	3	6
Larynx	5	0	4	1	5
Vulva	5	0	0	5	5
Testis	5	0	5	0	5
Pleura	5	0	3	2	5
Gallbladder	4	0	2	2	4
Thymus	4	0	1	3	4
Peritoneum	4	2	2	2	6
Ovary	4	0	0	4	4
Non Epithelial, Non Melanoma Skin	4	2	2	2	6
Extrahepatic Bile Duct	3	0	2	1	3
GI Tract, NOS	3	0	0	3	3
Soft Tissue	3	1	0	3	4
Ampulla Vater	2	0	1	1	2
Biliary Tract	2	2	1	1	4
Bone	2	0	0	2	2
Spleen	2	1	1	1	3
Lip	2	0	2	0	2
Tongue	2	0	2	0	2
Parotid Gland	2	0	2	0	2
Nasal Cavity	3	0	2	1	3
Ureter	2	0	1	1	2
Urethra	2	0	0	2	2
Trachea	1	0	1	0	1
Tonsil	1	0	1	0	1
Pericardium	1	0	1	0	1
Vagina	1	0	0	1	1
Fallopian Tube	1	0	0	1	1
Uvula	1	0	1	0	1
TOTALS	1,277	109	541	736	1,386

Ten Most Prevalent Cancers Diagnosed for 2010 by Gender
2010 National* and St. Joseph Comparative Incidence

*Source: American Cancer Society



FEMALE

	Nationally*		St. Joseph Medical Center
Breast	28.0%	Breast	46.1%
Lung	14.0%	Lung	12.5%
Colorectal	10.0%	Colorectal	6.1%
Corpus Uteri	6.0%	Melanoma	4.9%
Thyroid	5.0%	Corpus Uteri	4.2%
Non-Hodgkin's Lymphoma	4.0%	Pancreas	3.9%
Melanoma	4.0%	Lymphoma	3.4%
Kidney/Renal Pelvis	3.0%	Brain/CNS	2.7%
Ovary	3.0%	Bladder	1.9%
Pancreas	3.0%	Kidney/Renal Pelvis	1.8%



MALE

	Nationally*		St. Joseph Medical Center
Prostate	28.0%	Prostate	30.9%
Lung	15.0%	Colorectal	11.6%
Colorectal	9.0%	Lung	10.2%
Bladder	7.0%	Melanoma	6.3%
Melanoma	5.0%	Pancreas	5.9%
Non-Hodgkin's Lymphoma	4.0%	Bladder	5.0%
Kidney/Renal Pelvis	4.0%	Lymphoma	4.4%
Oral Cavity & Pharynx	3.0%	Kidney/Renal Pelvis	3.0%
Leukemia	3.0%	Esophagus	2.6%
Pancreas	3.0%	Stomach	2.2%

http://www.cancer.org/downloads/STT/Cancer_Statistics_2010.ppt
ACS does not include in situ carcinomas except of the bladder in their annual rates. St. Joseph Medical Center's rates are based on all reportable analytic tumors as defined by the Commission on Cancer and includes both invasive and in situ carcinomas.

* Analytic Cases: Patients either diagnosed or diagnosed and/or received a portion of first course treatment at St. Joseph's Cancer Institute.

** Non-Analytic Cases: Patient received first course treatment elsewhere and presented to St. Joseph's Cancer Institute disease recurrence or progression.



FOCUS

GENITOURINARY (GU) CANCERS

MARC SIEGELBAUM, MD, DIRECTOR, UROLOGIC ONCOLOGY CENTER

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In 2010 in the United States, there were 193,000 new cases of prostate cancer diagnosed. Furthermore, there were 27,400 deaths from prostate cancer in that same time frame. At St. Joseph Medical Center, prostate cancer is the second most common cancer being diagnosed and treated at the institution - second to breast cancer. Thus, it obviously represents a significant amount of pathology. In this annual cancer report, I will review the appropriate evaluation and treatment for prostate cancer according to the most recent NCCN guidelines.

First and foremost, proper treatment is dependent upon life expectancy, additional co-morbidities, potential side-effects, and patient preferences. In order to make a proper diagnosis of prostate cancer, one must obtain a PSA level to include both the total and free PSA. We do not strictly adhere to one single PSA level, but rather it is adjusted appropriately based on one's age. Thus the magical four nanograms per cc is no longer the gold standard, but rather a range of proper PSAs are looked at depending on one's age. For example, a patient in his forties should not have a PSA greater than 2.5; a patient in his seventies may have a PSA as high as 5.5 before a red flag might be raised. We also look at PSA density, which is the total PSA level divided by the prostate volume in grams. Needless to say, a rectal exam is still crucial, as many prostate cancers are found by rectal exams despite having normal PSA levels. If any of the above testing is abnormal, that patient should be referred for an ultrasound-guided prostate biopsy. Once a biopsy is completed, the tissue is given a Gleason score, somewhere between 4 and 10. A Gleason score is based upon the appearance of the cells under the microscope and how aggressive the cells look. A Gleason

score of 5 is a very well-differentiated tumor. A Gleason score of 10, on the other hand, is a very aggressive and poorly-differentiated tumor. We also usually take 12 biopsies according to a template that is universally accepted amongst urologists. Out of those 12 biopsies, we record how many of them are positive. We also then record what percentage of each core contains cancer within it. A bone scan should be obtained for any patient who is low stage (T1 disease) with a PSA greater than 20, or intermediate stage disease (T2) with a PSA greater than 10, a Gleason score of 8 or higher, or higher stage disease (T3, T4 disease). A pelvic CT scan or pelvic MRI scan should be obtained in any patient who has high stage disease (T3, T4) or any patient with low or intermediate stage disease (T1 or T2 disease) if certain nanograms that urologists use suggest that there is a higher than 20 percent chance of having lymph node metastasis. If the CT scan or pelvic MRI scan is suspicious, then a lymph node biopsy may be indicated. Once all of this is done, the patients are placed into a high risk or low risk category.

Low risk of recurrent disease is anyone who is stage T1 to T2A, has a Gleason score of 6 or less, and has a PSA of less than 10 nanograms per cc. We are recommending active surveillance for any of those men who have life expectancies of less than ten years. For those men who have life expectancies between 10 and 15 years, we are recommending either a radical prostatectomy (almost always done robotically at St. Joseph Medical Center) or radiation therapy (IGRT or brachytherapy/seeding). Cryotherapy is not recommended as primary therapy for these types of patients.

Da Vinci™

We have performed more than 1,000 robotic radical prostatectomies, which have allowed us to perform the surgery:

- More quickly
- With dramatically less blood loss, on average of 100 cc's
- With shorter hospital stays; most often less than 24 hours
- With minimal to no post-operative narcotic pain requirements or epidural catheter requirements
- With shorter indwelling foley catheter times; generally seven to ten days as opposed to two to three weeks
- With much quicker return to normal activities; most patients are back to work within two weeks
- With return to continence being much quicker
- Sparing both sets of nerves; chance of potency is upwards of 70%
 - Any residual incontinence or erectile dysfunction can be corrected

Prostate Cancer Recurrence Risk Levels

- **Very low risk** - this is a new category that was developed in order to avoid over-treatment for prostate cancer, if treatment is truly not necessary. This applies to stage T1 disease, a Gleason score of 6 or less, a PSA of less than 10 nanograms per cc, less than three positive cores out of 12, 50% or less cancer in each core, or a PSA density of less than .15 nanograms per cc per gram. For those patients who have life expectancies of 10 years or less, active surveillance should be the only option for those patients. For those patients who have life expectancies of 20 years or less, that is considered an excellent option, albeit not necessarily the only option.
- **Intermediate Risk** - involves a stage T2B to T2C disease, a Gleason score of 7, and a PSA between 10 and 20 nanograms per cc. In that category of patients, active surveillance for men who have life expectancies of 10 years or less is still a very reasonable option. In those patients, robotic prostatectomy with or without pelvic lymph node dissection (not needed if Partin Nanograms suggest less than 2% chance of lymph node involvement) or IGRT radiation with or without combined brachytherapy ("seeds") and androgen deprivation therapy



Since 2005, the Cancer Institute has performed more than 1,000 da Vinci™ procedures.

(ADT) for four to six months can be considered. For inpatients with a life expectancy of greater than 10 years, active surveillance is not an acceptable option. They should be treated with any of the methods mentioned above. Finally in this category, brachytherapy (seeds) alone is not a good treatment option.

- **High Risk** - includes patients with T3A disease, a Gleason score between 8 and 10, and a PSA greater than 20 nanograms per cc. In those patients, the preferred treatment is IGRT radiation with combined androgen deprivation therapy, usually for at least two to three years. Another treatment option would be a robotic prostatectomy with pelvic lymph node dissection if there is no fixation of the prostate to adjacent organs.
- **Very High Risk** - includes men who have stage T3B-T4 disease. In those patients, treatment options include IGRT radiation plus androgen deprivation therapy, again for a minimum of two to three years, or robotic prostatectomy with pelvic lymph node dissection in very selective patients, usually very young ones with long life expectancies.



Dedicated GU Nurse Navigator,
Jennifer White, with a patient

PROSTATE CANCER

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In men who develop metastatic prostate cancer, we still have the ability to treat them, albeit with different techniques. Usually, androgen deprivation therapy alone or androgen deprivation therapy plus radiation are options for men with limited positive lymph nodal disease, but not for men who have M1 (distant metastases).

Once patients have been treated, they need to be monitored very carefully. Usually this involves a PSA check every 6-12 months for 5 years and then annually thereafter. If cancer recurs, 45% tend to recur after 2 years, 77% recur after 5 years, and 96% recur by 10 years. If a patient develops recurrence after robotic prostatectomy, adjuvant treatment is suggested. Adjuvant radiation therapy is beneficial in men with adverse pathological features found in their prostatectomy specimens, i.e., they have positive surgical margins, seminal vesicle invasion, or extra capsular extension. Adjuvant radiation therapy is also recommended with unfavorable positive surgical margins (greater than 10mm margin in more than three different sites). If patients have a persistent detectable PSA post-prostatectomy, that, too, may be a good indication for adjuvant therapies. If radiation is being

considered, it should be done before the PSA reaches 1.5 nanograms per cc, post-operatively. If the patient had positive lymph nodes from their surgical excision, one should consider androgen deprivation therapy once the PSA becomes detectable, as there is no survival advantage to doing it any earlier. After robotic prostatectomy, if the PSA fails to drop to undetectable levels or if it is undetectable initially and then rises on two subsequent checks or if the PSA doubling time is 10 months or less, this is a cause for grave concern. At that point, one should really consider repeat biopsy of the prostate bed to see if there is recurrent cancer in that area. One should also do a bone scan and a CT scan or MRI scan to look for obvious recurrent and/or metastatic disease. Prostatant scans (nuclear medicine scans) may be helpful as well. Patients who develop recurrence after radiation therapy should be considered for adjuvant therapy.

The definition of recurrence after radiation therapy is a rise in the PSA of 2 nanograms per cc over what the nadir level was post treatment. If the PSA does go up, a repeat biopsy of the prostate should be considered as well as bone scans, CT or MRI scans of the pelvis, and prostatant scans. Salvage therapy after recurrence from radiation treatment involves either a salvage prostatectomy, which can be a very morbid operation with significant increased complications, cryotherapy or even brachytherapy (seeds).

There are many types of treatments available for metastatic disease of the prostate. Almost all of them involve LHRH Agonists (to suppress testosterone levels of the body), given as an injection or subcutaneous implantation.

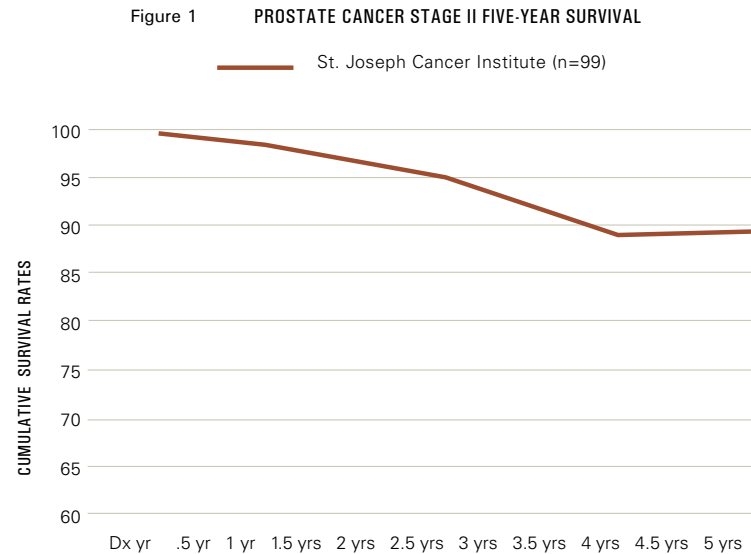
“The staff at the Cancer Institute have helped me above and beyond their normal requirements. As a patient at your facility I would certainly give it a ‘10.’ Congratulations for such a great facility plus all your excellent staff.”

∞ H.G.

After administering these medications, one must make sure that the serum testosterone is maintained in a castrate range that is less than 50 nanograms per cc. Some patients whose PSA levels drop initially and then increase again can be withdrawn from hormone treatment in a cyclical fashion, and sometimes there is improvement in their PSAs. Furthermore, anti-androgen medications can be added to the hormone injections to completely inhibit circulating testosterone that might be produced from the adrenal gland. In patients who require rapid reductions in their testosterone because of severe symptomatic metastatic disease, Ketoconazole with or without the use of steroids can be considered.

Patients who progress through androgen deprivation therapy can be considered for chemotherapy such as Docetaxel plus steroids or Docetaxel alone. For those whose disease continue to progress, Abiraterone would be another option, as well as clinical trials. Finally, a newer novel treatment, Provenge, is an autologous cancer vaccine created from the white blood cell fraction from patients themselves and is then re-infused back into the patient. In order to use this type of vaccine, they must have good performance status with minimal symptoms from their metastatic disease. Patients who develop symptomatic bone pain can have spot radiation to those areas with significant relief.

Patients who are maintained on androgen deprivation therapy ought to be given bisphosphonate medication, such as Zoledronic Acid infusions, or a newer medication, called Xgeva to protect the bones from pathological fractures.



Almost all prostate cancers diagnosed at St. Joseph are adenocarcinomas. We do rarely see sarcomas and/or lymphomas and transitional cell carcinomas of the prostate, but adenocarcinoma is the most common histology.

RADIATION ONCOLOGY

STEPHEN RONSON, MD, DIRECTOR OF STEREOTACTIC RADIOSURGERY

For the past two and a half years, the Radiation Oncology department at St. Joseph Medical Center has been proud to offer Stereotactic Radiosurgery (SRS) and Stereotactic Ablative Radiotherapy (SABR) treatments. Many patients refer to this form of treatment as “cyberknife” or “knifeless surgery.” The concept behind this form of treatment is to deliver high doses of radiation to a very small and precise volume with the goal of completely ablating tumors, while minimally affecting the normal surrounding tissue.

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At the Cancer Institute, we offer SRS/SABR treatments for tumors of the brain, lung, liver, and spine. These treatments are completely non-invasive. There is no anesthesia or sedation involved, and the patient does not feel any pain from the treatment itself. Whether our goal is to cure a patient of an early stage non-operable cancer or provide long-term palliative pain control to a patient with a Stage IV cancer, SRS/SABR technology has provided us with a highly effective form of treatment. In most cases, we are able to begin a patient’s course of treatment within two weeks of their initial visit.

In the coming months, we will be introducing our Varian TrueBeam linear accelerator. The TrueBeam linear accelerator will not only improve the quality and precision for patients receiving conventional daily radiation treatments, it will provide the platform for us to deliver the most sophisticated forms of SRS and SABR treatments with sub-millimeter precision while shortening time on the treatment table. While some centers require a patient to lie still on a treatment table

for more than 90 minutes to receive a treatment, TrueBeam technology allows us to deliver SRS and SABR treatments in less than 20 minutes. This cutting edge technology, combined with our experience, will allow the radiation oncologists of the Cancer Institute at St. Joseph Medical Center to provide the highest quality, most precise, and safest radiation treatments possible.



Dr. Stephen Ronson, director of Stereotactic Radiosurgery, and Dr. Jason Citron, director of Radiation Oncology, provide a wide spectrum of radiation-based therapies to St. Joseph patients.

SERVICES



Nurse Navigators - L-R: Susan Feild, Maria Conigliaro, Michele Riley, Bernie White, Diana Smith, Rose Menton, Jennifer White.

SUPPORT SERVICES

Cancer Institute

- ≈ Nurse Navigators
- ≈ Oncology Certified Nurses
- ≈ Clinical Research
- ≈ Ostomy Care
- ≈ Nutrition Counseling
- ≈ Psychosocial Support for Patients and Families
- ≈ Chemotherapy Class
- ≈ Genetic Counseling
- ≈ Tumor Registry
- ≈ Pain Management
- ≈ Lymphedema Services
- ≈ Financial Counseling
- ≈ End of Treatment Class
- ≈ Red Devils, Support for Breast Cancer
- ≈ LUNGS (Learning, Understanding, Navigating, Growing, Survivorship)
- ≈ SOS (Survivors Offering Support)
- ≈ Pink Ladies Breast Cancer Support
- ≈ Baltimore Women's Classic, Financial Support for GYN Cancers
- ≈ Lung Cancer Education Series

Medical Oncology & Hematology

- ≈ Serpick Infusion Center
- ≈ Inpatient Unit
- ≈ Biotherapy
- ≈ Management of Red Cell, White Cell, Leukocyte, and Platelet Disorders
- ≈ Chemotherapy
- ≈ Targeted Therapy
- ≈ Leukemias, Lymphomas–Hodgkin's and Non-Hodgkin's Lymphoma, Multiple Myeloma, and Myelodysplastic Syndrome

Surgical Oncology

- ≈ Robotic Prostatectomy
- ≈ Hepatic Resection
- ≈ Whipple Procedures
- ≈ Minimally Invasive Hepatic/Pancreatic Surgery
- ≈ Intrahepatic Microspheres
- ≈ Endobronchial Therapies
- ≈ Video-Assisted Thoracic Surgery (VATS)
- ≈ Esophagectomy
- ≈ Lung Resection/Post-Chemo Radiation

Radiation Oncology

- ≈ Stereotactic Radiosurgery (SRS)
- ≈ Varian Trilogy System
- ≈ CT Simulator
- ≈ Prostate Brachytherapy
- ≈ High Dose Rate Brachytherapy
- ≈ Mammosite HDR
- ≈ IMRT
- ≈ IGRT
- ≈ Respiratory Gating
- ≈ Stereotactic Ablative Radiotherapy (SABR)
- ≈ Varian TrueBeam linear accelerator

Spiritual Care

- ≈ Spiritual Counseling
- ≈ Advance Directives Counseling
- ≈ Caregivers Support Group

Community Participation

- ≈ Susan G. Komen Race for the Cure®
- ≈ Great Prostate Cancer Challenge
- ≈ Hopewell Run
- ≈ Relay for Life: American Cancer Society
- ≈ Baltimore Women's Classic Walk/Run

- ≈ Cancer Coalition: Baltimore County/Baltimore City Health Departments
- ≈ Smoke Free Maryland
- ≈ Look Good, Feel Better®
- ≈ Cancer Survivor Celebration
- ≈ Pancreatic Cancer Action Network: Purple Stride
- ≈ Sisters Network Baltimore Metropolitan
- ≈ Nueva Vida
- ≈ St. Clare Medical Outreach
- ≈ Maryland Regional Community Network Program
- ≈ Lungevity Walk

Community Outreach

- ≈ Screenings for Colorectal, Cervical, Prostate, Skin, Breast, and Head/Neck/Oral Cancers
- ≈ Ostomy Support Group
- ≈ Community Cancer Education
- ≈ Breast Cancer Education
- ≈ "Living with Lung Cancer" Education/Dinner Series
- ≈ Bereavement Support Group
- ≈ Patient, Family and Community Advisory Council

POINTS OF CONTACT

Hospital Information	410.337.1000	Genetic Counselor	410.337.1697	Nutrition Counseling	410.337.1246	Social Work	
Advance Directives	410.337.1109	Inpatient Oncology (7 West)	410.337.1390	Ostomy/Wound Care	410.427.1845	Inpatient	410.337.1550
Counseling	410.427.2124	Serpick Infusion Center	410.337.1841	PET/CT	410.427.2516	Outpatient	410.427.2124
Breast Center	410.427.5510	Multidisciplinary Clinic	410.427.5585	Pathology	410.337.1717	Spiritual Counseling	410.337.1109
Cancer Institute	410.427.5585	Nurse Navigators		Physical/Occupational Therapy	410.337.1330	Tumor Registry	410.337.1968
Clinical Research	410.427.4569	Breast	410.427.5509	Psychosocial Support	410.427.2124		
Community Outreach	410.427.2548	GI-GYN	410.427.2354	Radiation Oncology	410.427.2525		
Customer Service – Billing	410.337.1020	Lung & Esophagus	410.427.2321	Radiology	410.337.1441		
Doctors Directory	410.337.1337	Hematology, GU, Orthopaedic, Other	410.427.5434				



OUTREACH

CANCER OUTREACH PROGRAM

DONNA M. COSTA, MA, MHS

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The Cancer Institute Outreach Program encompasses an energetic team representing nursing, public health and smoking cessation disciplines, who provide a continuum of care. This includes cancer prevention and clinical trials education, cancer screenings, and navigation to underserved communities in Baltimore City, Baltimore County, and St. Mary's County. Notably, every uninsured/underserved person who is screened receives follow up services from our disparities nurse navigator. An important strength of the outreach program involves our continuous effort to build partnerships both internally and externally in our community, which enables the program to collaborate with groups who have similar goals. With funds from the National Cancer Institute Community Cancer Centers Program (NCCCP) and the American Recovery and Reinvestment Act (ARRA), the Cancer Institute was able to expand its community reach by providing more than 126 educational events and educating more than 3,600 community members from January through December 2011.

The Helping Up Mission has been coming to the aid of Baltimore City's poor and homeless since 1885. The Mission is now a long-term residential Spiritual Recovery Program for men with drug and alcohol addiction, focusing on the intellectual, physical, social, and spiritual needs of the men it serves. In 2011, the outreach team initiated a partnership with the Helping Up Mission to offer monthly cancer awareness programs and coordinated a link with Mercy Medical Center to provide the opportunity for screening colonoscopies for four eligible men through a Centers for Disease Control grant. We educated more than 250 men through four educational presentations on topics such as prostate cancer and diabetes, which were identified as critical to their health.

Med Chi, The Maryland State Medical Society, whose mission is to serve as Maryland's foremost advocate and resource for physicians, their patients, and the public, collaborated with St. Joseph Medical Center to provide a CME program on November 2, 2011, for 42 community physicians/health care providers regarding breast cancer screening and survivorship. Cancer Institute speakers for the CME included Dr. Michael Schultz, medical director of the Breast Center, Nisha Isaac, certified cancer genetic counselor, and Randy Tabb, MD, diagnostic radiologist.

Supportive programs for patients are also expanding. A newly established yoga class for breast cancer patients focuses on breast awareness and gentle movement appropriate for each participant to increase mobility and range of motion, increase flexibility (an important component of overall fitness), increase strength and stamina conditioning, and decrease stress levels. When talking with one of the participants about the benefit of attending the class, she responded with a wonderful smile on her face, "It's given me more energy."

The outreach team developed and implemented a community health assessment survey to determine by ZIP code, cancer prevention practices and access to health care providers, as well as knowledge and participation of clinical trials. Initial survey results were presented by our staff at the Fourth Annual Health Disparities Conference in New Orleans, Louisiana on March 27-29, 2011. Currently, more than 1,700 surveys have been completed; the metrics from these surveys have been instrumental in helping to achieve our goals.



ONE VOICE PROGRAM

“Every step of the way over the past two years has been bearable because of your team’s endless amount of knowledge, care, and love.”

∞ R.B.

PENNY GRAF, MSW, LCSW-C, OSW-C

In our work every day, we are challenged to provide the best possible health care for each patient and family regardless of disparities resulting from race, ethnicity, cultural beliefs, language barriers, lack of education, or having little or no health insurance. When it comes to breast health, there are added obstacles, including fear of a cancer diagnosis, inability to navigate the health care system, and lack of transportation. The Centers for Disease Control ranks Maryland eighth in the nation in the incidence of breast cancer (2007), and despite higher incidence among white women, death rates are 38 percent higher among African American women and Latinas.

As part of a new \$100,000 grant initiative, St. Joseph has joined with the American Cancer Society (ACS), South Atlantic Division, to develop a culturally-sensitive breast health education and screening program for underserved women in Baltimore County and Baltimore City. Together with our community partners, Nueva Vida and Sisters Network Baltimore Metropolitan, we are offering an 18-month program—called One Voice—targeting African American women and Latinas who are uninsured or underinsured. The goal of the program is to empower women, regardless of race, ethnicity, or socioeconomic status, to speak with One Voice when it comes to understanding the importance of breast health and gaining access to routine breast screening, as well as treatment for breast cancer.

Nueva Vida’s mission is to “inform, support and empower Latinas whose lives are affected by cancer and to advocate for and facilitate the timely access to state-of-the-art cancer care, including screening, diagnosis, treatment, and care for all Latinas.” Nueva Vida has served more than 3,500 patients and

families along the Maryland-Washington, D.C. and Virginia corridor. Sisters Network Baltimore Metropolitan is an Affiliate Chapter of Sisters Network® Inc., which is the only national African American breast cancer survivorship organization in the United States, with 3,000 members in more than 40 chapters around the country.

The One Voice program includes 12 educational sessions held in the community at churches, clinics, or senior centers, sponsored jointly by St. Joseph, ACS, Nueva Vida or Sisters Network Baltimore Metropolitan. The educational sessions offer information and resources on breast health and routine screening, in addition to guest speakers and testimonials by breast cancer survivors. The program will also offer three breast health screening days to be held at the Cancer Institute and transportation assistance for women in treatment. For any woman who needs additional diagnostic workup, our disparities nurse navigator will help her enroll in St. Joseph’s charity care program or the appropriate city, county, or state financial program to cover those costs. Any woman who is diagnosed with breast cancer through One Voice and who chooses treatment at St. Joseph Medical Center will receive the full support and services of our breast nurse navigator, oncology social worker, ACS patient resource navigator and survivorship nurse navigator, in addition to her medical care. As of November 2011, three educational events have been held, reaching more than 100 women. We are proud of the work we are doing and are looking forward with hope as we work with our community partners. Together, we will empower more women to speak with One Voice.



NCI COMMUNITY CANCER CENTERS PROGRAM
 St. Joseph Medical Center's Cancer Institute has been selected by NCI as a participating site in the NCCCP — the only one in Maryland.

ACCOMPLIS

NCCCP YEAR FOUR ACCOMPLISHMENTS

Clinical Trials

- Total of 36 trials are active (includes follow up of previously randomized patients)
- Closed three trials
- Opened 12 new clinical trials

Breast Cancer

- Surgery
- Chemotherapy
- Radiation therapy
- Metastatic disease

Lung Cancer

- Advanced lung cancer
- Genomic prognostic model for chemotherapy candidates
- Tissue banking
- Radiation therapy
- Multimodality therapy trials (chemotherapy/radiation surgery)
- Early drug development trial

Gastrointestinal Cancer

- Metastatic disease
- Early drug development trials

Supportive Care

- For breast, myeloma, and prostate cancers

- Strategies to increase accrual to clinical trials with focus on race, ethnicity, elderly, and low socioeconomic populations:

- Clinical Trials Navigator: The clinical trials navigator educates the underrepresented population about the importance of participation in cancer clinical trials and addresses barriers to recruitment.

- Community Outreach Clinical Trials Nurse: The outreach clinical trials nurse educates physicians in the community on the value of clinical trial participation. Physicians are educated on the importance of emphasizing to patients that treatment would not be compromised. The outreach clinical trials nurse keeps physicians abreast of current clinical trials.

- Participation in NCCCP webinars: Focuses on increasing clinical trial accruals to underrepresented populations.

Disparities/Advocacy

- Collaboration with Advanced Radiology which will provide 100 free screening mammograms for uninsured or underinsured women
- Received American Cancer Society One Voice Grant to provide 135 screening mammograms and clinical breast exams to uninsured women in collaboration with Sisters Network Baltimore Metropolitan and Nueva Vida, advocacy groups for African American and Latina women



Cancer Outreach Team: L-R, Donna Costa, Ann Israel, Christine Schutzman, Bernie White, Christine Watts

- Collaboration with St. Clare Medical Outreach program to provide smoking cessation services to medically underserved populations
- Received Socioeconomic Status Related Cancer Disparities Program grant to provide a Cervical Cancer Screening program for 60 uninsured or underinsured women
- Established collaboration with the Helping Up Mission, a residential program for addicted men, to provide monthly Cancer Awareness Programs.
- Provided 6 Community Cancer Screenings: (2) Breast, (2) Cervical, Prostate and Skin for a total of 256 community members (a 29% increase from 2010) and provided Nurse Navigation for 152 uninsured and underinsured persons with positive findings (a 51% increase from 2010)
- Published, NCCCP Disparities White Paper, ***How NCCCP Outreach Efforts Help Reduce Cancer Disparities in Oncology Issues***, July/August 2011

SHMENTS



St. Joseph team at the Baltimore Women's Classic 5K

Survivorship/Palliative Care

- Implemented "Living with Lung Cancer" Dinner Series: two 4- month programs for patients and families dealing with lung cancer, offering education and practical strategies for coping with the stresses of a lung cancer diagnosis. Topics included strengthening breathing techniques, physical therapy and exercise, the role of nutrition in managing the side effects of treatment, and complementary practices such as meditation, mindfulness, and acupuncture. An average of 8 – 10 participants attended each session.
- Expanded ASCO Treatment Summary & Care Plans to most disease sites including breast (50%), lung (16%), esophageal (12%), colorectal (7%), lymphoma (5%), uterine (3%), ovarian (3%), prostate (1%), anal (1%), cervical (1%), and pancreatic (1%).
- Continued Pink Ladies breast cancer support group, offering psychoeducation and mutual support. The group was initially introduced as a five-week series, offering topics selected by the group members, including strategies for coping with breast cancer and the side effects of treatment, healthy eating, physical therapy and lymphedema management, survivorship and transitioning to life after breast cancer, talking with children and grandchildren

about cancer, and spirituality. Twenty-five women participated over the course of the year. A survey was conducted in March 2011, and as a result, Pink Ladies was successfully reintroduced in the summer as a monthly series, with an average of 12 to 15 women per session.

- Expanded LUNGS (Learning, Understanding, Navigating, Growing and Survivorship) program to reach nine states. LUNGS is a peer-to-peer program offered in association with the American Cancer Society to match specially-trained mentors, who have completed treatment for lung or esophageal cancer, with newly diagnosed patients. The mentors offer on-going emotional support throughout treatment and beyond to the patient and family. The LUNGS program served 32 patients.
- Survivorship Nurse Navigator educated community regarding survivorship issues at the Annual Symposium.
- Smoking Cessation Counselor implemented ACS Fresh Start smoking cessation program for patients and family members. There were 18 participants.
- Smoking Cessation Counselor has counseled 136 patients and family members.
- Smoking Cessation Counselor standardized staff training for "Brief Intervention with Tobacco Users" (36 staff members were trained).
- Smoking Cessation Counselor educated staff at Oncology Grand Rounds and presented "Strong & Smart Program" to 13 participants.

Quality of Care

- Implemented Varian ARIA Oncology Electronic



St. Joseph Breast Center team at the Komen Race for the Cure.

Health Record on November 9, 2011, integrating outpatient oncology information.

- Added Nurse Navigator for GU, hematology, orthopedics, and other non-specific cancers and a Smoking Cessation Counselor through ARRA grant
- Expanded use of Access database from thoracic to GI, GU, GYN and orthopedic multidisciplinary conferences.
- Kicked off OEHR multidisciplinary planning committee.
- Integrated the use of My Personal Treatment Journal into the care of all new patients.
- Revised chemotherapy class for all new patients receiving chemotherapy.
- Increased number of end of treatment summaries given
- Initiated Patient, Family and Community Advisory Council to serve as a primary forum for discussing the development of the Cancer Institute's program priorities related to cancer prevention and screening, treatment, education, research, and survivorship and to establish and maintain strong collaborations between the Cancer Institute and its patients, families, and community.
- Piloted distress screening with thoracic patients with referral to appropriate support staff.
- Developed infusion center triage intervention protocol to standardize care and expedite patient care and flow in the infusion center.
- Developed SIC icon on all computers in patient care areas to house patient education and nurse reference materials for quick access and standardization.

† CATHOLIC HEALTH
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Our coordinated, multidisciplinary team of dedicated specialists will inspire patients and cancer clinicians alike by providing state-of-the-art screening, diagnosis, treatment, and support services to all patient populations in an efficient, compassionate manner.