

WHITTINGHAM CANCER CENTER  
AT NORWALK HOSPITAL

Annual Report  
2008

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Whittingham Cancer Center Annual Report 2008

Table of Contents

<b>Introduction</b>	<b>3</b>
<b>Radiation Oncology</b>	<b>5</b>
<b>Medical Oncology</b>	<b>6</b>
<b>Clinical Research Program</b>	<b>8</b>
<b>Department of Pathology</b>	<b>10</b>
<b>Department of Radiology</b>	<b>13</b>
<b>Department of Surgery</b>	<b>15</b>
<b>Smilow Family Breast Health Center</b>	<b>16</b>
<b>Tumor Registry</b>	<b>18</b>
<b>American Cancer Society</b>	<b>21</b>
<b>Cancer Genetic Counseling</b>	<b>22</b>
<b>Nutrition</b>	<b>22</b>
<b>Volunteers</b>	<b>23</b>
<b>Spiritual Care</b>	<b>24</b>
<b>Psychosocial Support</b>	<b>25</b>
<b>Patient and Family Support Group</b>	<b>26</b>
<b>Children’s Program: Crafting Ways to Cope</b>	<b>27</b>
<b>In-Patient Care</b>	<b>28</b>
<b>Complementary Therapies</b>	<b>29</b>
<b>Cancer Screening</b>	<b>31</b>
<b>Cancer Awareness Activities</b>	<b>33</b>
<b>Walk This Way... With Us</b>	<b>34</b>
<b>Patient Education</b>	<b>34</b>
<b>Professional Education</b>	<b>35</b>
<b>Neoplastic Disease Committee</b>	<b>37</b>
<b>PCE Study: Breast Cancer</b>	<b>38</b>
<b>PCE Study: Lung Cancer</b>	<b>42</b>

## **The Whittingham Cancer Center**

### **Annual Report 2008**

#### **Introduction**

We are proud to present the Annual Report for the Whittingham Cancer Center for 2008. This report highlights the accomplishments, challenges, and changes which occurred this year and exemplifies the mission of the cancer center. The mission encompasses an integrated and comprehensive approach to oncology care in a patient-sensitive environment and includes cancer prevention, early diagnosis and treatment with state-of-the-art technology, medical and radiation oncology, pre- and post-surgical cancer services, research protocols, nursing, psychosocial and nutritional counseling, hospice and bereavement services. Additionally, the Whittingham Cancer Center is the primary cancer education resource for health care professionals as well as community organizations and the general public.

The Whittingham Cancer Center receives approval from the American College of Surgeons' Commission on Cancer through a survey process, which is conducted every three years. This September our program was surveyed by Dr. Alexander Gunn, who performed an exhaustive on-site review and scrutinized our application. The members of the Neoplastic Disease Committee assisted in completing the application and participated in the one day site review. We feel this approval process emphasizes our commitment to improving survival and quality of life for cancer patients through setting standards, prevention, research, education and the monitoring of comprehensive quality care. We await the final notification by the Commission on Cancer within the next few months and we are very proud of the fact that Dr. Gunn reported that "We have an outstanding program and I am recommending to the American College of Surgeons that your program receive approval with commendation."

The Support Team continued to offer many fine programs this year. However, it was reported that not all patients are aware of existing support services. To rectify that, the team designed an intake form for new patients. The form lists the programs and services in the Whittingham Cancer Center and the patient is invited to check the items on which he/she would like more information. After six months, the team received a total of 260 requests for information about (listed in order of frequency) nutrition, clinical trials, support groups, education, complementary therapies, individual counseling, pain management, home care services,, finances, transportation, advance directives, image enhancement services and spiritual care. This format has led to increased participation in the support programs and improved relationships between new patients and the support staff.

In February 2008, the hospital contracted with Oncology Resource Consultants, Inc, (ORC) for consultative services in support of oncology strategic planning for Norwalk Hospital. The goal

of the process is to develop a 3-5 year plan for the cancer center including physical structure, research, technology and organizational structure. In April, Nancy Bookbinder, President of ORC, spent four days at Norwalk Hospital interviewing key people involved in oncology care. Since that time, Nancy has submitted her report and planning is underway to establish task force groups to address key issues including facility planning, affiliations, growth of breast, prostate, lung and gastro-intestinal cancer programs, survivorship and palliative care programs.

Norwalk Hospital is committed to several new initiatives for 2009 including upgrading and expanding the Whittingham Cancer Center. This strategic initiative parallels the formulation of the oncology strategic planning process and we look forward to continuing our mission to serve the community with optimum cancer care.

Mary Ellen Loncto, RN, MSN, AOCN  
Administrative Manager

Pradip Pathare, MD  
Medical Director

## **Radiation Oncology**

With early diagnosis comes the opportunity to cure with local treatment, either radical surgery or curative radiation. We have seen an increase in the number of complex treatments which have replaced the standard anteroposterior fields of yesterday. Increasingly patients demand and we offer the latest IG-IMRT (image guided intensity modulated radiation treatments). These are designed to deliver smaller, more precise radiation beams to tumor and spare surrounding critical organs. Our ability to spare the salivary glands in treatment of head and neck cancers, the rectum and bladder in treatment of prostate cancer, the kidneys, liver, and bowel in pancreatic cancer and similarly other tumor sites has allowed us to push higher cancerocidal doses of radiation.

Fiscal 2008 saw a 10 % increase in new patient consults to 393. The total number including repeat consults was 477. The total number of patient treatments was 7919, a 4.4 % increase over 2007. These treatments were of greater complexity and led to greater charge capture. The treatment numbers may decrease over time if future trials suggest that a higher daily dose and reduced number of fractions are equally effective and not associated with greater morbidity.

There is a daily barrage of advertising and patients and physicians need to be educated that the Tomotherapy, Cyberknife and proton beam machines all essentially do the same thing that our conventional Varian 21EX linear accelerator with cone beam CT image guidance can do, just a little bit differently. There are no studies demonstrating superiority to any of the approaches for the common tumors that we treat daily. We have taken delivery of our respiratory gating package, which will allow us to turn the beam on and off as the tumor moves in and out during respiratory excursions.

The Radiation Oncologists participate in all interdisciplinary meetings including the weekly tumor board and monthly gynecological oncology board as also other promotional activities in and outside the hospital. Dr. Pathare is Associate Clinical Professor at Yale and patients are assured of receiving state of the art care at Norwalk Hospital. We achieved the highest score of all departments in the hospital in the recently conducted physician satisfaction survey. Year after year our patient satisfaction scores have been excellent.

The future holds the promise of new emerging technologies, all of which require the layout of substantial amounts of money. The administration has made a commitment of its support for such an endeavor and we are hopeful that we can replace one of our existing machines with another powerful new weapon against cancer.

Pradip M. Pathare, M.D.  
Chief, Radiation Oncology

## **Medical Oncology**

The Whittingham Cancer Center (WCC) has been recognized as high quality cancer care facility delivering state of the art and compassionate care to cancer patients in Norwalk and its surrounding communities. The cancer center owes its continuing success in large part to its dedicated staff including nurses, medical assistants, ancillary, support staff, and a team of volunteers and physicians.

Since the submission of the last report, 4837 chemotherapy encounters were recorded as well as 4431 growth factor and hormonal injections. These numbers compare favorably with previous years and denote a 5.8% higher infusion rate than that of 2007. No conclusions can therefore be drawn at the present time regarding loss of market share which has been a concern. Patients enjoyed a comfortable, caring, empathetic, and nurturing environment in which these treatments were administered

The medical oncologists in conjunction with the Department of Radiation Therapy are responsible for the outpatient cancer care at the WCC. Apart from daily cancer care at the center, the following include the activities of the medical oncologists during the past year. Dr. Zelkowitz is a regular contributor to a nationally recognized breast cancer and teaching series. Dr. Zelkowitz is a member of the Board of the Breast Cancer Alliance. He serves as the Medical Director of the Smilow Breast Center. This center continues to draw a large population of women afflicted with breast ailments and helps guide these patients through stressful times during which radiologic and surgical procedures are often necessary. Maureen Major Campos, R.N, who replaced the retiring Nancy Sokolowsky as the Breast Center Navigator, arrives at Norwalk Hospital with a great deal of experience and is a valuable addition to this highly successful program.

Dr. Kesav Nair serves on the Board of Directors of the Mid-Fairfield Hospice. He participates twice annually as the oncology consultant and advisor to a Community Health Fair held in Stamford. Dr. Nair gave a lecture at the Medical Staff retreat at the Cranwell resort on Molecular Targeted therapy in Medical Oncology .He gave talks for the volunteers of the 2008 American Cancer Society Relay for Life in Wilton and manned the Norwalk Hospital public information table with Maryellen Loncto, Dr .Kathleen Lavorgna and Dr. Saras Nair. Dr. Nair received a plaque on behalf of Norwalk Hospital.

The Clinical Trials Program at the Center, led by Dr. Richard Frank has expanded substantially, with twenty trials now open. Patient accrual is occurring at a gratifying pace for these studies. Research nurses Linda Versea and Jennifer Long are instrumental in the ongoing success of this highly acclaimed program. Dr. Frank with other investigators, published an abstract in the Proceedings of the American Society of Clinical Oncology in 2008 on the efficacy and safety of the investigational drug CNTO328 with dexamethasone in Multiple Myeloma. He has submitted an article with others to the Journal of Clinical Oncology on a Phase I study of Sorafenib in patients with hepatic and renal dysfunction. It should be noted that our cancer center was the only community site allowed by the clinical trialist group CALGB .Dr. Frank's book "Fighting Cancer with Knowledge and Hope" has been accepted for publication and will be a valuable resource for cancer patients.

Dr. Andrea Ruskin serves on the Executive committee of the Department of Medicine and is on the voluntary teaching staff of Norwalk Hospital. Dr. Ruskin lectures widely on Immune Thrombocytopenia. Dr. Ruskin also serves as a medical oncology consultant to two insurance companies.

Dr. George Zahrah, whose expertise includes breast cancer and its genetic aspects, heads the Genetic Counseling Program for Breast and ovarian Cancers. Jessica Lipshlultz is the genetic counselor for this widely used program.

The physicians at the Cancer Center have been active in teaching medical students, house staff, nurses, and the public through a series of well-received lecture programs. The physicians have appeared on informative public television programs and held educational programs for the public on cancer-related subjects. The annual WCC lecture organized by Dr. Nair was on the subject of Urologic Malignancies by Dr. Dean Bajorin from Memorial Hospital for Cancer and Allied Diseases, NYC.

The annual Kirsten Frankenhoff Memorial Lecture was held in the Breast Cancer month of October. The speaker was Dr. Charles Loprinzi from Mayo Clinic, Minnesota.

Dr. Sumeet Chandra, one of the medical oncologists, left the practice to join a group in Florida, for personal reasons. We wish him the best in his future endeavors.

With astounding progress being made in the areas of molecular biology and genetics of cancer in the diagnostic as well as therapeutic fronts, significant advances are expected in the next two decades, The Whittingham Cancer Center is well poised to participate and contribute to these exciting developments. Our future plans should include strategies to maintain our market share, to expand the services we presently offer as well as and to include integrative and complementary oncology to further benefit our patients.

Kesav Nair, M.D.  
Senior Attending,  
Section of Medical Oncology,  
Dept of Medicine

## **Clinical Research Program**

This year has been one filled with research milestones and achievements for the cancer research program at the WCC. We continue to build on our record of offering the patients of Fairfield County some of the most innovative clinical trials available for the treatment of cancer. We have become the only community cancer center in the region to offer phase I clinical trials, testing new drugs before they become more available in later phase trials. We have accomplished this because of the wonderful cooperation of the hospital administration and institutional review board (IRB), which have allowed us to expeditiously proceed through the contracting and IRB approval phases of the clinical trials process. Leading oncology pharmaceutical companies such as Pfizer and Novartis are now turning to the WCC to help them study their new cancer fighting medicines in the earliest stages of development. This is of tremendous benefit to our patients, who are relieved of having to travel in order to find hope through a clinical trial.

We continue to excel particularly in the area of breast cancer research. We have exciting clinical trials for all stages of the disease including prevention and are among the national leaders in accrual to the pivotal trial (E5103) of chemotherapy plus the targeted therapy bevacizumab (Avastin) as adjuvant therapy. We are the only two site in CT to offer patients with Her2 positive disease, Herceptin plus panobinostat in a phase I trial.

Lung cancer is another area of strength as we have been able to open numerous studies of novel targeted therapies, such as Zactima, Axitinib, Sutent, Avastin and PF-00299804 (targeting EGFR 1-3), offering real hope to patients battling this disease.

Other cancers targeted by novel clinical trials at the WCC include colorectal, prostate and ovarian cancers, as well as the blood cancers multiple myeloma and lymphoma.

We have continued to maintain our status as member in good standing with National Cancer Institute Cooperative Group, Cancer and Leukemia Group B (CALGB) and our affiliate relationship with Hartford Hospital for the National Surgical Breast and Bowel Project (NSABP). These organizations enable us to access many of the same clinical trials offered at larger institutions. We reactivated our membership with the American College of Surgeons Oncology Group (ACOSOG) and are looking forward to initiating surgical protocols that meet the needs of our patients and interests of our surgeons.

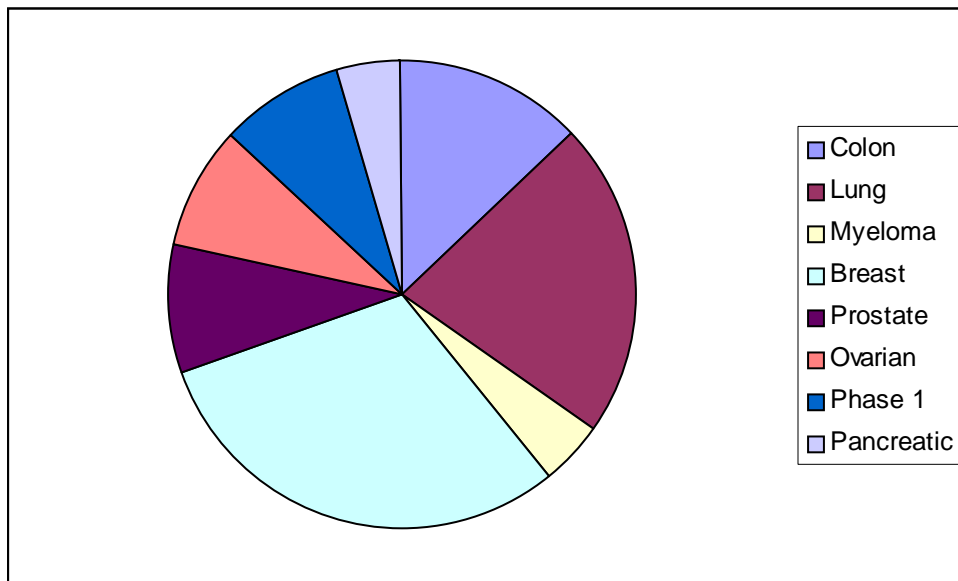
We continue to exceed the national average on clinical trial enrollment. Several of our studies have been completed, published or presented as follows:

- A phase 2 study evaluating the use of CNTO328 in combination with dexamethasone for patients with relapsed/ refractory multiple myeloma was presented at this year's ASCO conference.
- The CALGB study 60301 which studied the use of sorafenib for solid tumor malignancy patients with liver or kidney dysfunction was submitted to the Journal of Clinical Oncology for publication.

Our plans for the coming year include continued opening of new trials in the cancers most commonly encountered at the WCC as well as closing trials that accrue poorly. We intend to expand our growing phase 1 program and open new clinical trials in brain tumors and immune therapies. Linda Versea, APRN will continue to lead the effort across CT to recognize December as National Clinical Trials Initiative Month and work with the American Cancer Society to have this designation go national.

A major goal is to greatly improve community awareness of the cutting-edge therapies available at the WCC and to enlist philanthropy to aid in our expansion. We believe that the cancer research program is an integral part of the success of the WCC.

2007-2008 Cancer Clinical Trials:



## **Department of Pathology**

The Department of Pathology and Laboratory Medicine provides Anatomic and Clinical Pathology services for the patients of the Whittingham Cancer Center. The department continues to participate on the Tumor Board, on a weekly basis, the Neoplastic GYN Tumor Board, the Neoplastic Disease Committee, various educational conferences and monitors the statistics of cancer-related diagnoses.

The Department of Pathology diagnosed 155 breast cancer cases, 135 prostate cancer cases, 72 colorectal malignancies, 48 bladder cancer cases, 24 kidney cancer cases and 35 gynecologic malignancies, including ovary. Fourteen cases of esophagus and stomach cancer, 4 cases of small bowel malignancies and 22 cases of thyroid malignancies were diagnosed in the year of 2007.

Our breast cancer volume, in comparison to 2007 has dropped by 10 cases. Our volume for prostate cancer has increased by 7 cases. Our gyn malignancies have increased by 9 cases.

This data does not include in-situ malignancies, such as adenocarcinoma in-situ identified in colorectal polyps and squamous cell carcinoma in-situ of the cervix.

In the year 2007 the department reported 396 estrogen and progesterone receptors, and 146 Her2 neu analyses were performed. The data showed that 105 were reported as negative. Twenty-eight were reported as weakly positive or 2+, of which 22 were negative by FISH analysis. Three were equivocal by FISH and 3 were considered positive by FISH. Thirteen cases were reported as strongly positive 3+. The data, in comparison, to national data and published data is well within acceptable range.

The department performed 38 eGFR tests.

Flow cytometry was performed on 104 bone marrows. The lymph node volume has increased by 10 and is now 44. There has been a substantial increase in the number of bronchioalveolar lavages, specimens that have had complete immunophenotyping, for a total of 58. Forty-seven peripheral blood studies were performed.

In Surgical Pathology, the volume has increased by approximately 5%. In comparison to 14,564 cases diagnosed in 2007, we had a total volume of 15, 310. The increase is due to both inpatient and outpatient testing.

In Cytology the pap smear diagnoses has increased by approximately 1,000 cases for a total volume of about 3,500 cases.

The frozen sections diagnoses were correlated with permanent sections for a departmental accuracy of approximately 99%.

The department continues to perform above the published standards that have been statistically established for the accuracy and the correlation of permanent section to frozen sections.

In the Clinical Laboratory, the Department of Pathology has spent a significant amount of time reviewing send out tests this year, with a goal of reducing our costs. The preliminary analyses show that this is reducing the send out cost.

The department now has available free Kappa and Lambda testing on our Roche platform, which has reduced the turnaround time for those tests, which were send out tests.

The department now performs hepatitis testing in our Immunology Laboratory.

In Anatomic Pathology, the Histology Laboratory has been moved to a different location and new instrumentation, which is state-of-art, combines both staining and cover slipping on one analytical platform. Thus efficiencies have been improved in Anatomic Pathology as the Histotechs are now in the same location where the actual processing of the tissue is undertaken.

To continue the operational efficiencies and to increase patient safety in Anatomic Pathology, LIS is currently being upgraded, which will then result in automating the slide and block labeling with a barcode labeler.

In conjunction with the JCAHO patient safety goal of anticoagulation, the department currently has available Factor XA inhibitor studies with an acceptable turnaround time of 24-hours. We are currently evaluating the PTT testing for other anticoagulants, such as Hirudin and Agrotoban.

The Pathologists again participated in the College of American Pathologists proficiency testing exam in Cytology. All Pathologists who diagnose any gyn cytology have to participate in an annual accrediting examination. All the Pathologists and the Cytotechnologist completed this exam successfully.

Dr. Nair was invited to participate on the Advisory Board for Genetech for Her2 neu testing for the year 2008.

The department has actively pursued growth in Outreach. The department plans to develop draw stations in Norwalk. The department currently has a courier service to include three couriers and three cars and our outreach volume has increased by approximately 10% in the clinical laboratory.

In conjunction with our mission of growing outreach, we have developed certain testing in-house, such as a vaginosis screen in Microbiology.

The Department of Pathology has actively participated in the comprehensive review of the Cancer Center with the Norwalk Hospital's Oncology Consultant. All of the Pathologists have participated in focus groups for the various cancers and also the Pathologists have been assigned to participate within the conversations regarding strategic alliances for the Whittingham Cancer Center.

The recent ACOS review of the Whittingham Cancer Center results indicated that the Department of Pathology had no deficiencies.

The Department of Pathology has had a busy year of growth and successes. The department continues to actively participate in all aspects of the cancer program and has successfully implemented strategies to meet the needs and goals of the Whittingham Cancer Center.

Saraswathi Nair, M.D.

## **Department of Radiology**

The department of radiology at Norwalk Hospital is proud of the role it plays in the integrative care of oncology patients at Norwalk Hospital. Recognizing that the best Cancer Care requires a team approach, the radiologists at Norwalk Hospital are active participants in the weekly Tumor Board Conference at the Hospital. The close working relationship between radiologists, oncologists, surgeons, pathologists, and other member of the patient's oncology team provides a level of care usually available at only the largest academic centers. Care is delivered, here, however, with the compassion and individualized attention that are the hallmarks of this community hospital.

The department features the most advanced imaging techniques, including 64 slice CT, 1.5T MRI, Ultrasound, PET-CT, Nuclear Medicine with SPECT, Digital Mammography and X-ray. All studies are interpreted by radiologists from some of the finest training programs in the country. In addition, the Department of Radiology has its own fully-accredited radiology residency training program, part of our commitment to incorporate the latest teaching into clinical practice.

Within the department, 2008 has been yet another exciting and progressive year. The department has expanded its interventional oncology service, and now offers a full complement of treatment options, including radio-frequency ablation, cryoablation and chemoembolization. These minimally invasive procedures are able to precisely target tumors throughout the body via small catheters introduced through the skin rather than major surgery. In conjunction with our colleagues in the Department of Urology, we are able to percutaneously treat and ablate small renal tumors. We are also now participating in a program to treat Early Stage Lung Cancers with combined radiofrequency ablation and radiation therapy.

In the nuclear medicine division of the department, a new high-resolution camera has been installed, to more accurately image and detect the most subtle of findings. Indications for PET-CT continue to grow. The fused images from a PET scan and thin section high-resolution CT scan provide some of the most accurate means of detection of primary, metastatic and recurrent tumors.

Radiologists interpreting digital mammography are now able to provide immediate reports with the installation of Magview, our mammography digital reporting system. With an electronic link directly to the digital mammography review station and to computer aided detection, we are able to provide truly the highest level of breast imaging interpretation and reporting.

The new Cerner Radiology Information System (RADNET) has been fully implemented. This system provide seamless integration with the other hospital information systems, improves productivity and shortens the time for reports to be completed. In the near future, voice

recognition will be added to the system and will improve the turnaround time of radiology reports.

At Norwalk Radiology and Mammography Center, the Hospital's out-patient imaging partner, a third MRI has been installed. The new unit, a state-of-the-art GE 1.5T magnetic resonance imaging scanner, provides expanded and exceptional capability to detect and stage tumors wherever they arise. In particular, with this technology, the radiologists can continue to provide the most accurate diagnoses of breast, gynecologic, neurologic, abdominal, hepato-biliary and musculoskeletal neoplasms. Once again, this ability to support the needs of our surgical and medical oncologic colleagues is one of the missions of the radiologists at Norwalk Hospital.

At NRMC, the new, expanded Connecticut Breast Center opened its doors in September 2008. The center is completely digital, with full-field digital mammography linked to computer aided detection; ultrasound, and osteoporosis/bone density testing. The center also provides a complete complement of biopsy services, including mammotome/ stereotactic biopsy, ultrasound guided biopsy and aspiration and breast mri guided biopsy and localization. In addition, it is the first in Fairfield County to offer the GE Essential digital mammography machine- with the largest field of view available. Recognizing that not all patients have the same build and body habitus, this unit allows for fewer images, and with that, less compression, less pain and diminished radiation exposure. NRMC continues to be Fairfield County's leader in Breast MRI, and will be among the first in the nation to showcase Cadstream version 6- the most advanced tool for breast mri computer aided detection.

We have worked closely with the Hospital to dramatically reduce the cost of a breast MRI for high risk women (those with a personal history of breast cancer along with dense breasts) who not eligible for managed care reimbursement. Recognizing that managed care has become increasingly restrictive in allowing women to have breast MRI, we have made this important test affordable by dramatically reducing the cost of this procedure for these women.

Finally, recognizing the anxiety and stress associated with waiting for breast care, particularly when an abnormality is present, the Connecticut Breast Center has pioneered 'Detection to Diagnosis in 48 hours'- a commitment to patients and doctors that when patients have a breast-related problem, they will receive rapid, accurate and compassionate care. This unique program has been tremendously well received by the patients in our community and their physicians.

David Gruen, MD  
Department of Radiology

## **Surgical Oncology**

Norwalk Hospital surgeons continue to play an integral role in the screening, diagnosis, and treatment of tumors of the breast, lung, colon and rectum, genitourinary system, head and neck, skin and central nervous system. Tumors of the brain and spinal cord, head and neck, breast, lung colon, rectum, kidney and prostate are presented at weekly multidisciplinary tumor board where all medical, surgical and radiation therapy options are discussed.

Norwalk hospital surgeons continue to utilize and refine minimally invasive surgical techniques whenever possible. The advantages for the patient include less scarring, decreased pain, shorter recovery and better procedures. In this tradition, Norwalk Hospital surgeons now use the acclaimed da Vinci® Surgical System. According to Jonathan E. Bernie, M.D., Chief of Robotic Surgery at Norwalk Hospital, "The da Vinci® Surgical System is a great benefit to our patients because it provides 3-D visualization and greater precision enabling the surgeon to perform complex surgery using a minimally invasive approach." This greater control allows significant protection to surrounding tissues resulting in preservation of normal tissue and function, improved outcomes and shortened recovery.

Robotic-assisted radical prostatectomy and gynecologic procedures including myomectomy are already being performed at Norwalk Hospital. Many other surgical procedures performed today using standard laparoscopic technique may be performed more quickly and easily using the da Vinci® Surgical System. This is because robotic surgery delivers increased clinical capability while maintaining the same "look and feel" of open surgery.

The department of surgery is proud to be able to offer our patients the latest in high tech surgery while maintaining the individualized and personalized care of a community hospital.

Robert Lincer, M.D., F.A.C.S.  
Cancer Liaison Physician

## **Smilow Family Breast Health Center**

After thirty-one years of service at Norwalk Hospital, Nancy Sokolowski, RN, Breast Health Specialist, retired in April 2008. Nancy was a fierce champion of women diagnosed with breast cancer and worked tirelessly to promote prevention and early detection programs for breast cancer.

In August 2008, we welcomed Maureen Major Campos, RN, MS, in the role of breast health navigator/specialist. Maureen spent thirteen years as a clinical nurse specialist at New York's Memorial Sloan-Kettering's Evelyn H. Lauder Breast Center. Maureen brings a wealth of experience and expertise to the position.

The Smilow Family Breast Health Center continued to provide many programs for people at risk for breast cancer and those diagnosed with breast cancer. Genetic Counselor Jessica Lippshutz, MS, met with 67 women for evaluation of hereditary breast cancer between January and September of this year. Six hundred and sixty women received breast and cervical cancer screenings through the state-funded Early Detection Program. Barbara Schmitt, Registered Dietitian, provided nutritional consultations for sixty-one women with breast cancer. Support Groups continued throughout the year for those newly diagnosed with breast cancer as well as those who have completed treatment. A new support group was initiated in September 2007 for those who have a partner or spouse with breast cancer. This "Partner's Group" is co-facilitated by Nancy Gennaro, LCSW, and volunteer Jeff Pivor; attendance has gradually increased throughout the year and feedback from attendees has been outstanding.

Another addition to the breast program in 2008 is the Image Enhancing Program providing wig consultation, make-up assistance, and hair cutting for those patients undergoing treatment. The lymphedema program was expanded to include on site evaluation by an occupational therapist with lymphedema training. Through the Hartenbaum Foundation, lymphedema sleeves are given free of charge to appropriate patients. Many products for patients with breast cancer are now available in the conveniently located Norwalk Hospital Health Emporium and these include camisoles, scarves, hats and make-up.

Educational activities for the public continued throughout the year at health fairs, community talks, cablevision presentations and more. To highlight Breast Cancer Awareness Month a fashion show at the Stamford Mall took place with breast cancer patients modeling outfits escorted by Norwalk Hospital physicians. Also in October Norwalk Hospital employees were able to make mammogram appointments with ease on their lunch break in the hospital cafeteria. Many patients and employees joined the "Making Strides Against Breast Cancer" event in October sponsored by the American Cancer Society.

Breast cancer tumor board continued to be held monthly with Drs. Borgan and Vahdat alternating each month. Their expertise guided the treatment planning discussions of new cases of breast cancer presented by the medical and radiation oncologists.

Discussion continued this year on the possibility of a surgeon taking on the role of Medical Director of the breast center. The breast center continues to be led by Richard Zelkowitz, MD, whose passion and expertise provides exemplary guidance and management for the breast program. Program Assistant Zarek Mena coordinates the myriad of programs and services and provides the helpful and compassionate presence to those who come to the Smilow Breast Health Center.

## **Tumor Registry**

The Cancer Registry at Norwalk Hospital operates within the guidelines of the American College of Surgeons Commission on Cancer and the Connecticut State Department of Health Cancer Registry. The Cancer Registry reports directly to the multidisciplinary Cancer Committee, which directs the long range planning and general activities of cancer services.

The Cancer Registry provides a system to monitor all cancer patients diagnosed and/or treated at our facility. The Cancer Registry is responsible for the collection, management and analysis of data on cancer patients. The Cancer Registry works closely with physicians, hospital administrators, and health care practitioners to maintain ongoing records of cancer patients' history, diagnosis, treatment and outcome. This information can be used for education, research and lifetime follow-up.

The Cancer Registry maintains data on 18,429 patients which have been entered in the database since our previous reference date of January 1, 1985. Since our new reference date of January 1, 1997, as per approval of the Cancer Committee, 9,260 patients have been entered. There were 714 new cancer cases accessions in the cancer registry in 2007, 593 of which were analytic cases and 121 were non analytic cancer cases. For 2007 there were 593 female patients and 345 male patients. The top five cancer sites for 2007 were breast, prostate, lung, colo/rectal and bladder.

Lifetime follow up must be maintained on all patients diagnosed and/or treated at our facility. The Cancer Registry has consistently exceeded 90% follow-up rate with an average rate of 94%.

The Cancer Registry is committed to maintaining quality patient data to assist in the care and treatment of cancer patients at Norwalk Hospital.

Karen Bua, BA, CTR



## **American Cancer Society**

On Sept. 8, 2008, the American Cancer Society and Norwalk Hospital joined forces in the fight against cancer as both organizations signed a collaboration agreement to work together on a number of key initiatives, including promotion of the Society's free cancer information services and clinical trial matching program, support programs for cancer patients and their families, cancer education and prevention programs, and advocacy and outreach efforts throughout the community.

Through the collaborative agreement, the American Cancer Society and Norwalk Hospital will work together to provide and promote supportive services to patients at Norwalk Hospital, including the Society's Personal Health Manager, a free patient care management tool that helps to inform and organize cancer patients in their first year of diagnosis (36 distributed in Norwalk), the Reach to Recovery<sup>®</sup>/Volunteer Survivors Team which provided support to 12 women diagnosed with breast cancer in need of support, education, and resources, Road to Recovery, a program that provides free transportation to cancer patients to-and-from treatment (15 patients, 16 new drivers and 154 rides in Norwalk), and Look Good ... Feel Better<sup>®</sup> workshops that provide physical and emotional renewal for women undergoing treatment. Norwalk Hospital hosted five Look Good...Feel Better sessions over the past year, serving thirty-one patients and teaching them beauty techniques to help restore their appearance and self-image during chemotherapy and radiation treatments.

In addition, Norwalk Hospital and the Society will network within the Greater Norwalk area to share new information about cancer care, especially prevention and early detection services and promote awareness about cancer prevention, and early detection among the employees of Norwalk Hospital. Norwalk Hospital and the American Cancer Society have truly built a strong foundation of partnership. The comprehensive approach to cancer prevention, treatment, and recovery of the American Cancer Society and Norwalk Hospital becomes even stronger with a shared promise to not just work in partnership in the fight against cancer, but to work as one.

Maureen Gianni  
American Cancer Society  
Community Executive, Health Initiatives

## **Cancer Genetic Counseling**

The Whittingham Cancer Center renewed its contract with Yale Cancer Center for Cancer Genetic Counseling for the eleventh year in a row. Danielle Camfield, MS, provided counseling for thirty-three patients in 2008. Twenty-four patients had a personal or family history of breast and/or ovarian cancer and eleven patients had a personal or family history of colon cancer, renal cell cancer, pancreatic cancer, and/or thyroid cancer. Eighteen patients had BRCA ½ testing. Seventeen patients were negative for BRCA with three variants and one positive BRCA. Two patients had PTEN testing and results are pending.

Due to budget restraints, the contract for 2009 includes eight genetic counseling sessions instead of twelve. Our goal for 2009 is to refer more people for counseling and testing for hereditary colon cancer. Working with the Department of Gastroenterology, we hope to identify those people who are at high risk for hereditary colon cancer and make them aware of the cancer genetic counseling services.

For patients at risk for hereditary breast cancer, Jessica Lippschutz, MS, provides counseling and testing in the Smilow Family Breast Health Center.

## **Nutrition Counseling**

Barbara Schmidt, MS, RD, CDN, continued to provide nutritional counseling for patients with cancer. Appointments are available every other week at no charge to the patient. During the past year, Barbara saw 70 patients for a variety of nutrition-related issues, including weight loss, mouth sores, decreased appetite, and desire to learn how to maintain good nutrition during and after cancer treatment, seeking information about complementary medicines and herbals and ways to cope with symptoms related to the gastro-intestinal tract. Patients have reported the sessions have been very helpful and informative. Due to the new patient intake form, more patients are aware and taking advantage of, this worthwhile service.

## **Volunteers**

In 2008 a total of thirty-six volunteers worked in the Whittingham Cancer Center.

Fourteen volunteers assisted patients in the chemotherapy infusion suite by providing snacks, blankets, companionship, etc. for a total of 1,373 hours. Ten volunteers assisted the valet parking, four volunteers assisted patients and staff in the radiation waiting area, two volunteers helped at the art program, and two volunteers assisted the nurses in the clinical research area. Volunteers also provided much needed assistance for the skin screening clinic in September and the prostate screening clinic in September.

<b><u>Location</u></b>	<b><u>Number of Volunteers</u></b>	<b><u>Number of Hours</u></b>
Chemotherapy infusion suite	14	1,373
Cancer Center Valet	10	816
Radiation Waiting Area	4	596
Support Group	2	20
Cancer Center Art Program	2	91
Blood Lab Runners	2	60
Clinical Trials	2	267
<b><u>TOTAL</u></b>	<b><u>36</u></b>	<b><u>3223</u></b>

## Spiritual Care

The Norwalk Hospital Department of Spiritual Care and the Whittingham Cancer Center have a strong relationship built on several years of programmatic collaboration. This year we continued this work with our two Oncology Adjunct Chaplains, Lynn Crager and Karen Montieth, supported by the WCC and the Department of Spiritual Care. They serve inpatients on 6 East and the outpatients in the Cancer Center.

Our goal has been to provide for the spiritual well being of patients and their families journeying through the world of cancer diagnosis, treatment and recovery or with the process of coming to terms with a terminal prognosis. Chaplains are committed to the holistic care of those encountering a crisis of transition or dealing with whatever questions of meaning occur during one's illness.

From Lynn Crager:

*Presenting relaxation techniques to patients and others, I have been invited to open meetings of various cancer support groups with meditation. I continue to work with Dr. Amy Zabin, Music Therapist, in offering "Music and Meditation" to patients, staff, and visitors two Thursdays a month. Having satisfied all requirements as of May 2008, I am now fully certified to present Peggy Huddleston's Prepare for Surgery, Heal Faster Workshop. I have worked cooperatively this year in developing a book group for staff members of the Whittingham Cancer Center.*

From Karen Montieth:

*Having completed my first year at WCC, I participated in the annual "Walk-a-thon" and the annual Service of Remembrance for patients of the WCC. Along with Lynn Crager I attended an educational seminar led by Dr. Jimmie Holland of Memorial Sloan-Kettering on "Psycho-oncology" and another led by Dr. Kathleen Resnack on "Caregivers: How to Care, Cope and Create a Good Life." The primary focus on my work has been meeting cancer patients "where they are at" in the cancer center and on 6 East.*

Our services include one-on-one spiritual care and counseling, prayers and rituals (as appropriate), bereavement and grief counseling, and support groups for patients and staff. We are proud of the team with whom we work in the Cancer Center and look forward to another successful year.

Rabbi Jeffery M. Silberman, D.Min.  
Director of Spiritual Care and Clinical Pastoral Education

## **Psychosocial Support Services**

We have completed another active and exciting year of providing a full-range of psychosocial support services to our patients and families at the Whittingham Cancer Center. Our psychosocial staff remains in-tact with two part-time clinicians, Nancy Gennaro, LCSW and Michelle Dailey, LMFT who work 24 and 32 hour respectively.

We continue to focus primarily on patient assessment and therapeutic interventions related to living with a diagnosis of cancer as we follow patients from the time of diagnosis through treatment and, when needed, terminal care and bereavement. Additionally, we continue to provide individual and family counseling, crisis intervention, community resource referrals, interdisciplinary-team care coordination, and ongoing program development. Our support services are also extended to staff members and volunteers who work with cancer patients.

The Norwalk Medical Group oncology office remains the primary source of patient referrals for psychosocial care. We are routinely called upon for patients dealing with a new diagnosis or recurrent disease, anxiety, depression, children and family issues, and financial concerns. We also assist when needed with securing medications or transportation to and from treatment. Additional referrals come from Radiation Medicine, IVOP, 6E and other in-patient units, as well as home care and community service agencies, and from patients/families themselves. Weekly meetings continue with the oncologist on-call and the interdisciplinary team for patient discussion and planning. We also meet weekly with CT Hospice Home Care, twice monthly with Mid-Fairfield Hospice, and periodically with Vitas Hospice Home Care.

This year the Support Team has launched a new initiative to meet lung cancer patients within 24 hours of admission to the hospital (72 hours on the weekend) in an effort to intervene early with any problems. We are also developing a psychosocial self-assessment tool for this population. Another initiative addresses how best to evaluate and meet new patients on their initial visit to the oncologist office. We have added a check-off list of available services and programs to patient orientation packets, and we follow-up with phone calls to offer information/appointments as requested. These initiatives have proven to be very effective in identifying and addressing specific patient needs.

Our well attended general Cancer Support Group became so large that we resorted to a waiting list until it became apparent that a second group was needed. In June 2008, our second group began meeting weekly on Wednesday evenings and is growing into another successful group (See Cancer Support Groups.) Our Crafting Ways to Cope children's program, now in its fourth year, continues to be very successful (see Crafting Ways to Cope). We launched a pilot program for Partners of Breast Cancer patients which was viewed as very helpful for those who attended. We intend to continue the partner's group this fall, and have scheduled four meetings with the hope that increased publicity will lead to improved attendance.

Michelle and Nancy remain very involved in our major annual fundraiser, "Walk This Way ...With Us", which was extremely successful this year with results totaling over \$200,000. Michelle continues her work with Spanish speaking patients and families, assuring them an opportunity for proper support and education. Nancy continues to be involved in supervising the

Arts at the Center program, which offers a weekly class to patients and caregivers as an additional modality to reduce stress and express feelings.

We are very pleased with the new programs which have been initiated by our Support Team this year, and we look forward to the challenges and rewards of providing the highest quality of psychosocial services to patients and families at the Whittingham Cancer Center in 2009.

Nancy Gennaro, LCSW  
Michelle Dailey, LMFT

### **Patient and Family Support Group**

The Patient/Caregiver Support Group was extremely well attended again this year, averaging 16 attendees weekly, with a range of 6 to 25. Nancy Gennaro, LCSW and Bridget DeBartolomeo, RN co-facilitate the group, with Melinda Brockwell, APRN as back-up for vacations.

It has been a difficult year of loss and change for the group. Three long term group attendees who were loved and respected by all succumbed to their disease. A fourth member is seriously ill and in the hospital at this time. The group derived support from each other as they tried to cope with these losses; however this continues to be a very difficult time for all.

Our attendance this year was quite high and we felt that the numbers warranted starting a second general Support Group on Wednesday evenings. Thus far, the Wednesday group remains small, ranging from 3-12 attendees. However, the group process has been excellent, and in general, has resulted in tremendous support for those in attendance.

We maintain the same format of splitting into patient and caregiver groups on the first and third weeks of the month. This continues to be a popular and unique format, with some members choosing to attend specifically on “split night”.

We extend our thanks to Novartis who continues to support our Tuesday group with dinners on the first week of each month. We also thank several group members who have contributed to our general fund for group dinners. This allows members to come directly to group after work, and still enjoy a nutritious meal.

Our general Support Groups continue to change and grow, and we feel they are a significant source of support and education to our patients and families at the Whittingham Cancer Center.

Nancy Gennaro, LCSW  
Bridget DeBartolomeo, RN, MSN

## **Crafting Ways to Cope**

Now in its fourth year, the *Crafting Ways to Cope* support program is a collaborative effort between the Whittingham Cancer Center and Cancer Care, Inc. This special program has been tremendously successful and is designed for children ages 5-12 who have a parent diagnosed with cancer. Michelle Dailey, LMFT, Family Therapist, and Nancy Gennaro, LCSW, Oncology Social Worker from the Whittingham Cancer Center continue to facilitate the program with Marilyn Wald, MSW, certified in art therapy, from Cancer Care, Inc.

*Crafting Ways to Cope* groups run monthly in the fall and spring as a series of free two-hour workshops in which families dealing with cancer come together with others in the same situation. The program is funded by grant monies from Cancer Care, Inc. along with private donations made to the Whittingham Cancer Center. A major goal of the program is to help children feel safe and supported as they explore questions, concerns, and fears about cancer in their family. Michelle Dailey and Marilyn Wald continue to co-facilitate the children's groups, using various crafts and games to engage children in expressing feelings and sharing stories with others. A unique offering of the program is our concurrent parents group, facilitated by Nancy Gennaro, in which parents can learn coping skills, communication strategies, and gain knowledge to help guide their children through the family's cancer experience. Many parents report that a positive outcome has been to bring cancer "out of the closet" and into the normal flow of family communications.

This past year we presented six *Crafting Ways to Cope* groups beginning in September with *Family Night* followed by five *Kid's Groups* in subsequent months. Enrollment continues to be about 6-10 parents and 8-12 children at each of the sessions, designed to be fun, interactive, and informative. And as always, we include pizza dinner for all!

We continue to be very grateful to our dedicated group of volunteers who helped throughout the year with the *Crafting Ways to Cope* program, and we look forward to another successful collaboration with Cancer Care, Inc. during the 2008-2009 season.

Michelle Dailey, LMFT

## **In-Patient Care**

6 East is the oncology, hospice, and medical/surgical overflow unit. Patients are admitted to this unit for a variety of reasons including pain management, symptom management, chemotherapy and hospice care.

The nursing staff on 6 East attends The Oncology Nursing Society's Chemotherapy and Biotherapy Course and The Basic Oncology Core Course upon hire to provide them with the basic knowledge and skill to provide care to the patient experiencing cancer. Sangeetha Chacko RN and Mary Gregory RN successfully completed the Chemotherapy and Biotherapy Course. Kesha Dancy RN, Laura DiPreta RN, and Jayani George RN have successfully completed the Basic Oncology Core Course.

Tammy Neubauer RN and Mary Gregory RN attended the Oncology Nursing Society's annual Congress in Philadelphia, Pa. We appreciate the financial support of a fund set up many years ago in memory of Ellie Gummer which was established and receives continued support for the purpose of furthering the education of oncology nurses.

Amy DiGiugno RN received the Nightingale Award for Excellence in Nursing in May. Amy was nominated for this award because of her dedication and compassion towards her patients and their families. Amy has been an oncology nurse at Norwalk Hospital for 21 years. She is our beacon on the night shift.

Dorothea Tucker PCT received the Norwalk Hospital Exemplar of Excellence Award in May. Dorothea is a Patient Care Technician on 6 East who over the course of her 40 years at Norwalk Hospital has shared countless laughs, hugs, kisses, and tears with her patients and their families.

Marie Edward was recognized in Norwalk Hospital's News Scan in the Service Excellence Section as being "Simply the Best". A letter was written by a patient's daughter about Marie. Marie was described as "the most hard working, most likeable and respected individual who helped tremendously to make my mother's stay in the hospital a pleasant one."

We have an active Unit Council on 6E. A few of our accomplishments this past year were education to other units during breast cancer awareness month promoting breast self exams and mammography, creation of a Sunshine/Recognition Club and monthly recognitions, a patient belongings check list, social activities as a unit with our families, information cards that can be given to families with the unit and patient's telephone number, and personalized bereavement cards.

Alison Varcoe, RN, OCN  
Patient Care Manager, 6 East Oncology

## **Complementary Therapies**

### **Arts at the Center**

This has been a very satisfying year at the Whittingham Cancer Center for the Art Program. We have engaged in a variety of activities and have reached more people affected by cancer.

The attendance has been consistently between 8-10 participants. There have been many new people who have recently been diagnosed and seem grateful to have a way to exchange feelings and ideas with other survivors, and keep busy with something productive.

To encourage the feeling of artistic sharing and group support, a long range project on which they worked was a communal quilt. Each person made one section in whatever modality they chose (patchwork, collage, paint, sewing). These individual squares were joined together with a common material and created a handsome quilt which is now hanging in the Center. This quilt is a wonderful example of what the art program is all about.

The group as a whole takes great pride in the joyfulness with which they pursue their artwork. The emphasis has always been that the process is more important than the product. There is a natural inclination to want to do something well, so the project generally becomes a source of personal pride. This comes from having learned a new skill, accomplishing something which had initially seemed too difficult, or just moving beyond their resistance. It is this process of complete concentration, perseverance, and letting go that is the ultimate reward in doing any art project. The product becomes the by-product of the process.

This year the group has worked more intensely with watercolor, sewing on netting, collage, and lately beading with watch faces. The atmosphere is one of support, caring and thoughtfulness coupled with the feeling of freedom to broach any concerns which are pertinent to our being together at the Cancer Center.

Suzy Miles  
Art Therapist

### **Reiki**

During the past year, our Reiki Master Denise Gross passed away after a short illness. Denise's gentle and compassionate manner deeply touched everyone she came in contact with and we continue to miss her.

281 Reiki sessions were offered to patients and caregivers in 2008. The sessions were held in the in the Smilow Family Breast Health Center. Two Reiki masters provided this service, Linda Nugent and Andrea Meisner-Gottlieb. In addition to these out-patient sessions, Linda and Andrea

went to the chemotherapy infusion suite and to 6 East inpatient unit where they were well received. Patients continue to find reiki provides relaxation and to decrease pain, nausea and fatigue.

### **Massage**

Dee Hiatt, Licensed Massage Therapist, saw 110 patients during the past year for massage therapy. Forty minute appointments with Dee were available every Wednesday morning throughout the year. Dee also provided massage to in-patients and out-patients who were receiving chemotherapy. Patients reported a decrease in anxiety, pain and fatigue after massage therapy.

### **Music**

Amy Zabin, PhD, continues to come to the Whittingham Cancer Center every other week to provide music therapy for out-patients and in-patients. Amy uses the flute or guitar and plays music individualized for each patient. Often the session evokes memories which allow patients to reminisce and to relax. In addition to this, Amy and Lynn Crager, Pastoral Care Minister, hold “Music and Meditation” sessions in the hospital chapel for cancer patients, caregivers, staff and others. During these 40 minute sessions, spiritual readings, music and meditation are provided. Attendance fluctuates with a low of five to a high of twenty and all report this a peaceful experience.

## Cancer Screening

### Breast and Cervical Cancer Early Detection Program

Breast and cervical cancer screening is implemented throughout Connecticut for medically underserved women through a comprehensive program called Breast and Cervical Cancer Early Detection Program. This program is provided through the Smilow Family Breast Health Center at Norwalk Hospital. We screened 697 women for 2008 fiscal year. The primary objective of the screening program, offered free of charge through the Connecticut Department of Public Health and the Federal Centers for Disease Control and Prevention, is to significantly increase the annual number of women who receive breast and cervical cancer screening services and diagnostic follow-up, as appropriate. The serving populations are as follows:

#### Ethnic Background:

White: 125/ Black: 71/ Asian: 46/ Hispanic: 455

#### Numbers of patients in each age group:

Age	19-30	31-39	40-45	46-49	50-55	56-60	61-65	66-70	71-75	76-80
#	49	80	124	162	184	86	62	7	1	2

#### The Screening and Diagnostic Services Include:

- Office visits
- Screening and diagnostic mammograms
- Breast biopsies
- Breast ultrasounds
- Fine needle aspirations
- Pap tests
- Colposcopies and colposcopy-directed biopsies
- LEEP
- Surgical consultations
- Clinical breast exams
- Case Management

Women diagnosed with cancer or pre-cancerous conditions through the free Breast and Cervical Cancer Early Detection Program do receive treatment for the cancer or pre-cancerous condition through a special Medicaid coverage group. A woman qualifying under this Medicaid group is also eligible for full Medicaid benefits, not only those relating to the diagnosed cancer or pre-cancer condition. Coverage under this group may remain in effect for as long as the woman continues to meet the program's eligibility factors.

Kiki Tarasidis, Case Manager

### **Prostate Cancer Screening**

Prostate cancer screenings were held three times during 2008. On April 22, 2008, Peter Dodds, MD, screened 52 men at the AmeriCares Clinic. All results were within the normal range.

On September 4, 2008 and September 24, 2008, free screenings were held in the Norwalk Hospital Specialty Clinic for men between the ages of 40 and 75 who do not have a urologist or primary care physician and have no history of prostate cancer. 49 men were screened with PSA testing and DRE examinations by Drs. Dodd, Bernie and Batter. There was one abnormal DRE in this group. Educational information on prostate cancer was given to all participants.

### **Skin Cancer Screening**

On Saturday, September 6, 2008, a free skin cancer screening was held at the new offices of the Connecticut Dermatology Group at IPark. Drs. Steven Kolenik, Stuart Bender, Jennie Nally, MD and John Jazinski, P.A., screened one hundred and ninety-three people; fifty-seven were referred for biopsy and/or further follow-up. All participants received skin cancer prevention information.

## **Cancer Awareness Activities**

*SpinOdyssey*, a premier fitness charity event was held in February 2008 in Westport to benefit breast cancer research activities. At this event, oncology nurse clinicians distributed information about breast cancer clinical research trials at the Whittingham Cancer Center and about ways to prevent cancer. The Whittingham Cancer Center received \$22,503 from *SpinOdyssey* for breast cancer clinical research trials.

The *Super Colon*, an 8-foot tall, 20-foot long replica of a human colon was on display at the 5<sup>th</sup> Annual Walk This Way...With Us, in May 2008. This inflatable, interactive colon teaches people about the risks, symptoms, prevention, early detection and treatment options for colorectal cancer. The Whittingham Cancer Center nurse clinicians guided people to walk through the *super colon* to see healthy tissue, tissue with non-malignant diseases as well as tissue with various stages of colorectal cancer.

*Look Good/Feel Better*, a program that helps women cancer patients improve their appearance and self-image, was held four times during 2008. Due to the increased numbers of attendees, the program will be held six times in the coming year. This is a joint event by the Whittingham Cancer Center and the American Cancer Society.

Other events, including health fairs, occurred with increasing numbers this year and included:

<b>Date</b>	<b>Place</b>	<b>Number of Attendees</b>
May 1, 2008	Tauk Industries, Norwalk	75
May 2 and May 12, 2008	Norwalk Hospital Cafeteria	100
May 14, 2008	King Industries, Norwalk	50
May 16, 2008	Norwalk Hospital, Women's Health Awareness Day	150
June 1, 2008	Opening of IPark	300
June 7, 2008	Norwalk Community College	1,000
June 25, 2008	Doubletree Hotel, Norwalk	30
September 21, 2008	Darien, CT, Road Race	75
September 24, 2008	Zoto International, Darien	75
September 27, 2008	Stepping Stones Museum, Norwalk	200

At all of these events, nurse clinicians educated the public on cancer prevention and the need to be screened at regular intervals. They also distributed information on the services and programs available to patients and their families at the Whittingham Cancer Center.

## **Walk This Way...With Us**

The fifth annual Whittingham Cancer Center benefit walk was held on Saturday, May 17, 2008 and it was successful in every sense of the word. Approximately 1,500 people came – patients, doctors, hospital administration and staff, government officials and members of the community. The DNR band played, butterflies were released to honor those who passed away from cancer, people walked three or five kilometers observing the one hundred “flags” to honor people or advertise a business. Proceeds from the walk totaled \$209,242 which will be used to support our programs and services here at the Whittingham Cancer Center.

Tammy Zelkowitz, Co-chairperson, summed up the event in these words of gratitude to the volunteers who made the walk such a success:

*“Success is sweet! I am ever so grateful to each and everyone of you for your hard work, dedication and commitment making this year's 2008 Walk this Way... A memorable event. We did it well and together. The weather was spectacular helping to bring out people in droves. We truly were very organized making set up and breakdown a breeze. I hope you had the opportunity to enjoy yourself, mingle, and observe the crowd while you worked. It was an emotional journey for many with lots of kisses, hugs and tears.”*

## **Patient Education**

November 14, 2007, “Cancer and the Young Adult: Issues and Solutions,” Richard Frank, MD, presenter. This program was a collaborative program with the Leukemia & Lymphoma Society, Center for Hope, and the Whittingham Cancer Center.

April 2, 2008, “Updates in the Treatment of Lymphoma and CLL,” Richard Frank, MD, presenter. This program was a collaborative program with the Leukemia & Lymphoma Society and the Whittingham Cancer Center.

May 14, 2008, “Updates in Lymphoma: A Review of the 2007 American Society of Hematology Annual Meeting,” Richard Frank, MD, presenter. This program was a collaborative program with the Leukemia & Lymphoma Society and the Whittingham Cancer Center.

August 14, 2008, “Compassionate Communication for Couples Affected by Cancer,” Les Gallo-Liver, ACSW, presenter. This program was a collaborative effort of the Whittingham Cancer Center, the American Cancer Society and Cancer Care.

## **Professional Education**

October 4, 2007, "Update on CML Management," Michael Mauro, MD, presenter.

October 18, 2007, "Novel Agents in the Treatment of Multiple Myeloma," Bimalangshu Dey, MD, presenter.

November 14, 2007, "Clinical Discussions of Metastatic Breast Cancer," William Sikow, MD, presenter.

November 15, 2008, "Osteoporosis," Stuart Novack, MD presenter.

November 15, 2007, "Colorectal Cancer: Disease Incidence and Treatment Options," Bridget DeBartolomeo, RN, MSN, presenter.

February 14, 2008, "Newest Results form the San Antonio Breast Cancer Conference," Richard Zerkowitz, MD, presenter.

February 28, 2008, "Sexuality in the Cancer Patient," Mary Mangan, RN, MSN, presenter.

April 1, 2008, "Care of the Patient with Leukemia," Andrea Ruskin, MD and Bridget DeBartolomeo, RN, MSN, presenters.

April 2, 2008, "Clinical Trials," Lawrence Wickerham, MD, presenter.

April 3, 2008, "Making Sense of Myelodysplastic Syndromes: From Diagnosis to Treatment," Azra Raza, MD, presenter.

April 10, 2008, "Identifying and Managing Hereditary Breast and Ovarian Cancer," George Zahrah, MD and Jessica Lipschutz, MS, presenters. This was presented at the 8<sup>th</sup> annual Women's Health Symposium/Medicine Grand Rounds, Norwalk Hospital.

April 17, 2008, "Early Stage Breast Cancer," Andrea Silber, MD, presenter. This was presented at Medical Grand Rounds, Norwalk Hospital.

May 1, 2008, "Current Debates in the Treatment of Her2 positive Breast Cancer – a Case Based Discussion," Kevin Fox, MD, presenter.

May 2, 2008, "Early Adjuvant Treatment in Breast Cancer," Ajay Bhatnager, MD, presenter.

June 12, 2008, "Practical Strategies for the Application of Novel Agents for the Frontline Treatment of Multiple Myeloma," Robert Schlossman, MD, presenter.

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June 26, 2008, “Lung Cancer Update,” Andrea Ruskin, MD and Bridget DeBartolomeo, RN, MSN, presenters.

August 11, 2008, “The Evolving Role of Erbitux and Implications of K-Ras Mutations in Metastatic Colorectal Cancer,” Marwan Fakih, MD, presenter.

September 16, 2008, “Medtronic Pump: What’s It All About?” Melanie Sayer, BS, MS, presenter.

## Neoplastic Disease Committee

Chairman	Pradip Pathare, MD
Surgery	Peter Dodds, MD
Medical Oncology	Richard Zelkowitz, MD
Radiation Oncology	Pradip Pathare, MD
Obstetrics & Gynecology	John Garofalo, MD Patrick Nugent, MD
Diagnostic Radiology	David Gruen, MD
Pathology	Saraswathi Nair, MD
Cancer Liaison Program	Robert Lincer, MD
Administration	Mary Ellen Loncto, RN, MSN
Nursing	Alison Varcoe, RN, OCN, Nursing
Quality Improvement	Margo Dwyer, Director, Quality Improvement Claire Davis, VP, Quality Management
Social Services	Nancy Gennaro, LCSW
Cancer Registry	Patricia Tersigni, CTR Karen Bua, CTR
Clinical Research	Linda Versea, APRN Jennifer Long, APRN
Pain and Palliative Care	Kesav Nair, MD
Pastoral Care	Rabbi Jeffrey Silberman
American Cancer Society Liaison	Maureen Gianni
Vice-President, Administration	Lisa Brady

9/2008

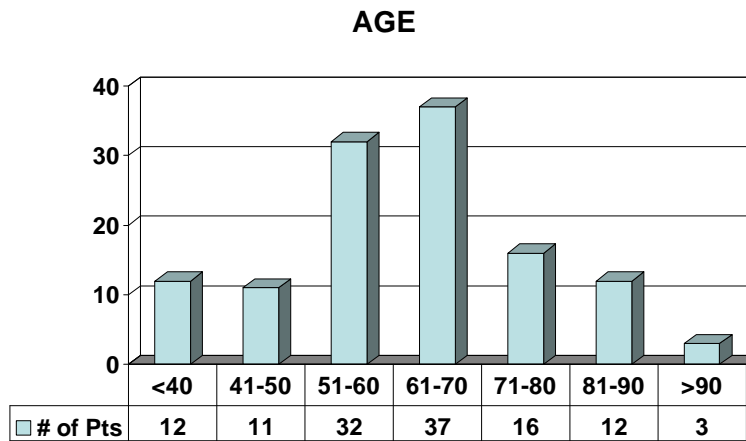
**PCE/Tumor Registry Q/A Study for 2008**

**BREAST CANCER**

**Pradip M. Pathare, M.D.**

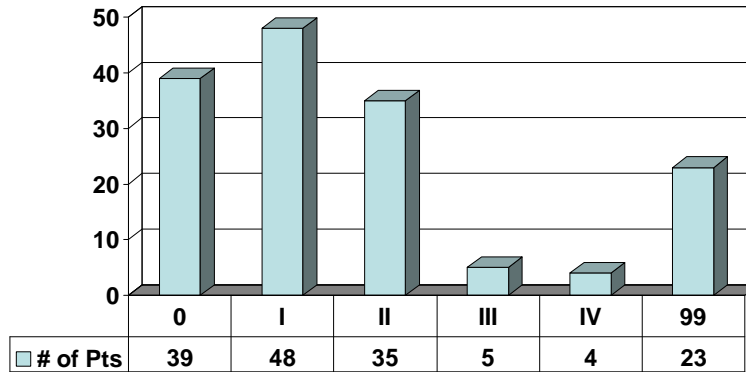
The indications for adjuvant hormonal and chemotherapy treatment in breast cancer have been increasing, as new data from clinical trials begin to mature. This study was conducted to evaluate our experience at Norwalk Hospital for all breast cancers first diagnosed or treated in the year 2007.

There were a total of 154 patients with the median age of 68 years. All patients were female (1 % of breast cancers occur in males) and the age distribution is shown in the accompanying graph.



Of the 154 patients, 39 had stage 0 non invasive disease, mostly ductal carcinoma in situ with 3 cases of lobular carcinoma in situ. All patients with invasive cancer underwent a sentinel node biopsy and when positive and when appropriate, an axillary lymph node dissection was accomplished for pathological staging and prognostic information for recommendation on adjuvant therapy.

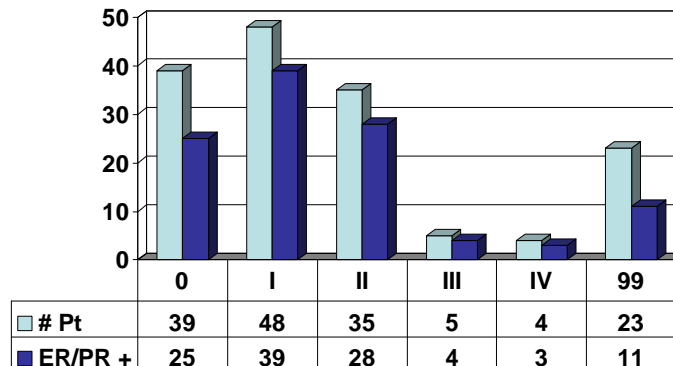
### STAGE



As a general rule, patients with stage 0, stage I and stage II underwent a chest x-ray alone for metastatic work up. Patients with stage III and IV underwent additional radiographic work up that included a bone scan, CT scans of the chest, abdomen and pelvis, spine or brain and MRI when needed. The stage distribution is shown in the following graph. 122 patients had early stage disease, stage 0, I or II and 9 patients had more advanced disease, stage III or IV. Stage was not recorded in the tumor registry records in 23 cases.

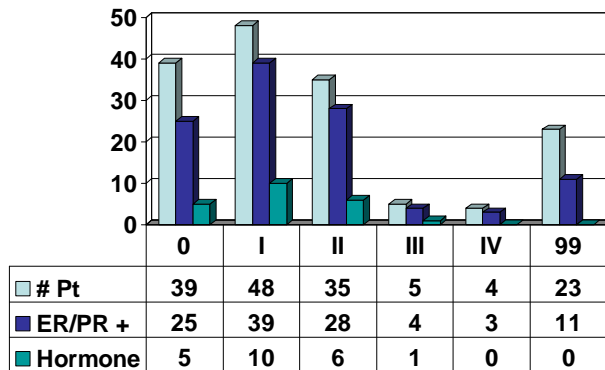
The estrogen and progesterone receptor status plays a vital role in determining the choice of adjuvant therapy. Estrogen and/or progesterone receptor positive tumors were present in 99 patients, the estrogen and progesterone receptors were both negative in 22 patients and the receptor status was unknown in the remaining 33 patients.

### ER/PR Status and STAGE



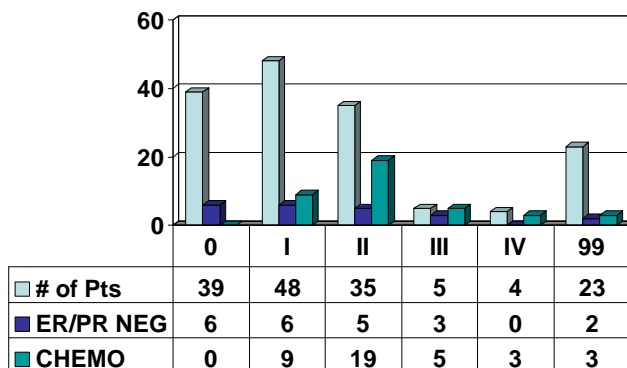
The register data was queried to find out how many patients with hormone receptor tumors were on Tamoxifen or Aromatase inhibitor therapy. 22 patients were recorded as being on such treatment and are shown by stage in the following graph.

**ER/PR Status/STAGE/Hormone Therapy**



The registry was also queried to find out how many patients received adjuvant chemotherapy broken down by stage. None of the stage 0 patients received chemotherapy, 9 stage I, 19 stage II, 5 stage III and 3 stage IV patients were on chemotherapy. The data was then queried to find out how many of the patients with estrogen and progesterone receptor negative tumors were on chemotherapy and this data is shown on the following graph.

### STAGE/ER STATUS/CHEMO



This short study was performed to evaluate if the appropriate fraction of patients are receiving adjuvant hormone therapy, but served as a Quality Assurance for Tumor Registry Abstractions. A very large proportion of patients whose tumors are positive for estrogen or progesterone receptors would be expected to be on hormone therapy. It would appear that this data is not completely inclusive as only 17 patients of the 74 hormone dependant stage I, II and III patients were listed as being on Tamoxifen or Aromatase inhibitor treatment. Similarly the Stage was not recorded in 23 of the 154 patients.

The tumor registry will send a follow up note to all physicians who were managing these patients and update estrogen and progesterone receptors and staging and use of adjuvant hormone therapy. Physicians are required to provide the registry with the appropriate information so that the most accurate information resides in the hospital tumor registry. All cancer programs approved by the Commission on Cancer of the American College of Surgeons report data to the central Registry. This pooled data forms the basis of reports on national trends and outcomes and suggests treatment guidelines. We must make an effort to ensure that our statistics are accurate and timely.

The author wishes to acknowledge Ms. Karen Bua, Tumor Registrar for her help in gathering this data.

**PCE 2008 Breast Study**

## **Patient Care Evaluation Study for 2008**

### **LUNG CANCER**

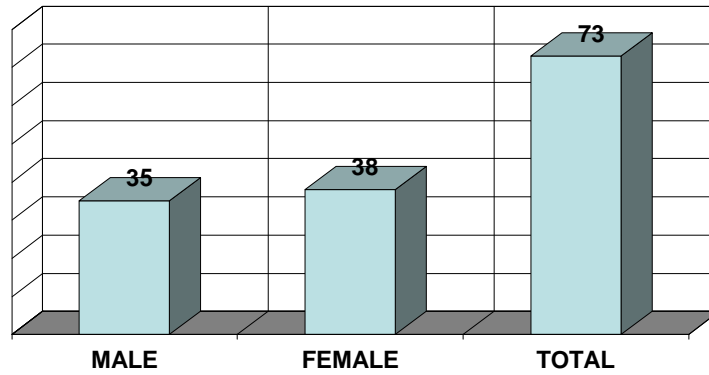
**Pradip M. Pathare, M.D.**

With 215,000 new cancer cases estimated for 2008, lung cancer remains the most prevalent cancer in the United States. 162,000 men and woman are expected to die as a result of lung cancer, a number that exceeds the deaths from breast, colon and prostate combined.

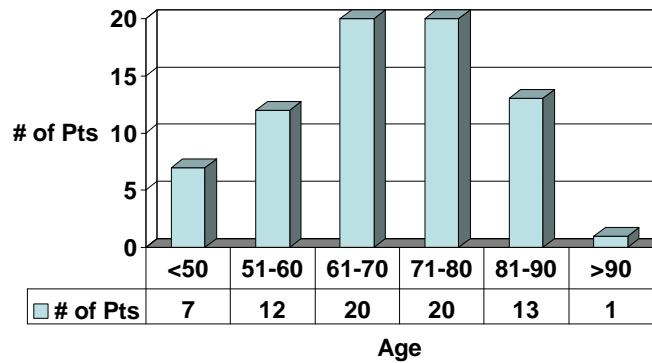
The Hospital Tumor Registry database was used to review the incidence, stage at diagnosis, treatment modalities and outcome of all lung cancers diagnosed or treated at Norwalk Hospital for the year 2001. Additional information was collected by review of all radiation charts and other information in medical records. In 2001, there were 7 small cell lung cancers and 73 non small cell cancers for a total of 80 cases. As treatment and outcome of small cell lung cancers is quite different from the non small cell cancers, this review will focus only on the non small cell lung cancer.

**AGE AND SEX:** The age and sex distribution of the 73 patients with non small cell lung cancers is shown on the following graphs. There was slight preponderance of females (38) to males (35). The median age of all patients was 75 years, with 7 cases, occurring in patients younger than age 50.

**Patient Sex**

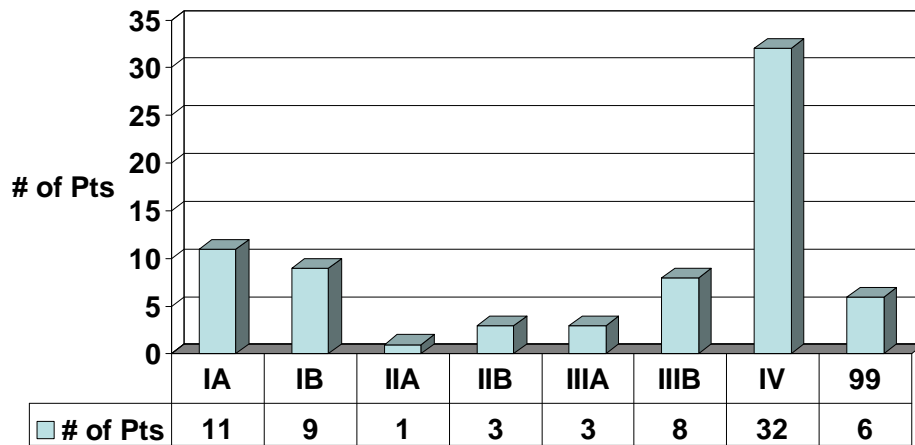


**Patient Age**



Over half of the patients were symptomatic at the time of their diagnosis. Less than a third of the patients were diagnosed as either an incidental finding during work up for another illness or as a screening test. The stage grouping is as per the 6<sup>th</sup> Edition of the AJCCS TNM staging manual. As the accompanying graphs demonstrate, nearly half of all patients already had distant metastases at the time of diagnosis and considered incurable. 24 patients were diagnosed with stage I and II disease with a higher probability of being cured. Stage III accounted for 11 patients.

## STAGE

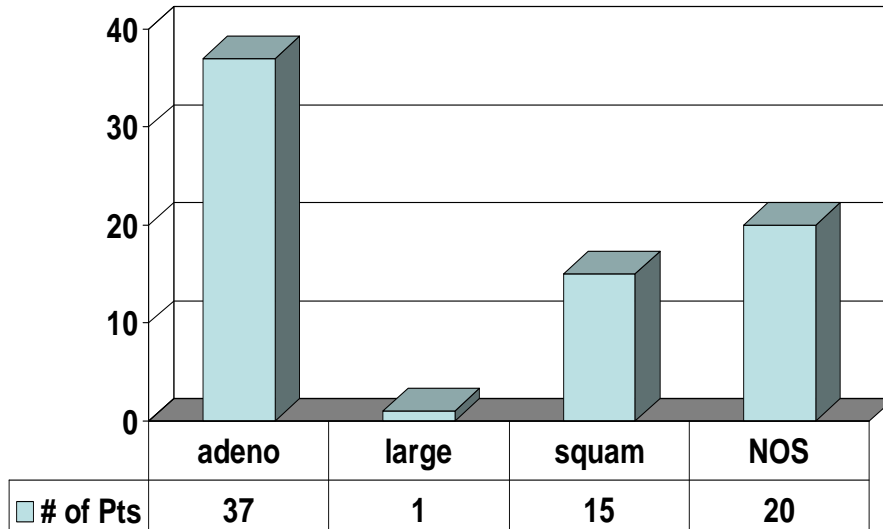


**STAGING WORK UP:** All Patients underwent a chest CT scan before a biopsy was attempted. A small number had a successful transbronchial biopsy. The majority of the patients had undergone a CT guided needle biopsy of either the primary lesion or metastatic lesion, usually liver or lymph node and on occasion bone. One patient presented with pathological fracture and diagnosis was made during the open reduction and internal fixation procedure. Six patients were either too old or too sick to undergo biopsy and the diagnosis was based on extremely strong clinical grounds and radiographic data.

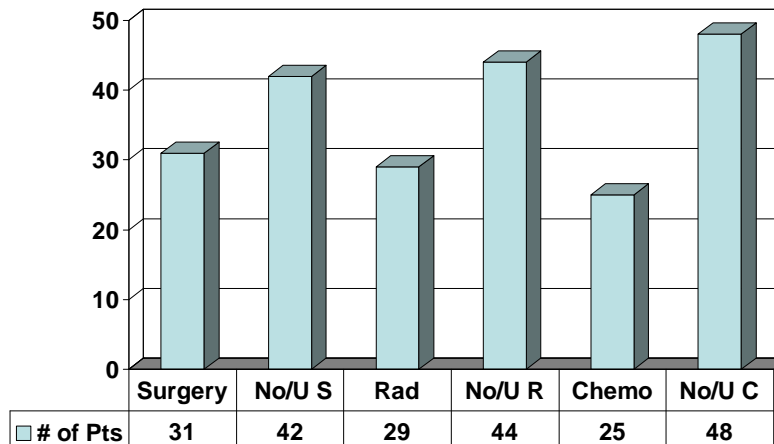
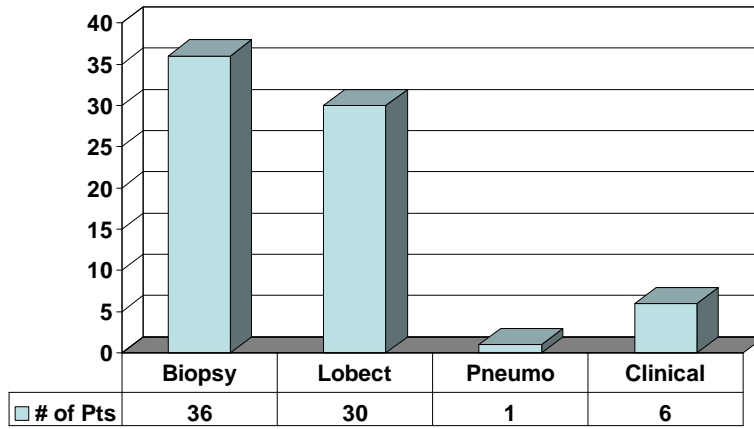
Once the diagnosis of the non small cell cancer of the lung was made, all patients underwent extensive metastatic work up that included CT scan of the chest, abdomen and pelvis and a bone scan. If radical resection was contemplated a brain MRI was also performed. In 2001 only a few patients had undergone a PET/CT for staging. The staging shown in the accompanying chart includes patients who had radical surgery and in whom a pathological stage was available. For non surgically staged patients, the staging was based on clinical information at the time of the initial treatment.

**HISTOLOGY:** The majority of non small cell lung cancer patients had a non squamous histology. Adenocarcinoma was the predominant subtype accounting for 37 cases. There were 15 squamous cell cancers. 20 were classified as epithelial cancer and it is believed that they would have a similar spread between non squamous and squamous cell cancer, a distinction that is more important in today's era of targeted therapies.

## Histology



**SURGERY:** Surgery played a role in half of the patients with lung cancer, either for diagnosis or treatment. Of the 73 patients, 31 had undergone a thoracotomy. One patient underwent a pneumonectomy and the other 30 had less than an entire lung removed, either a lobectomy or bi-lobectomy. 42 patients either did not undergo surgery or the information was unknown in the registry data.

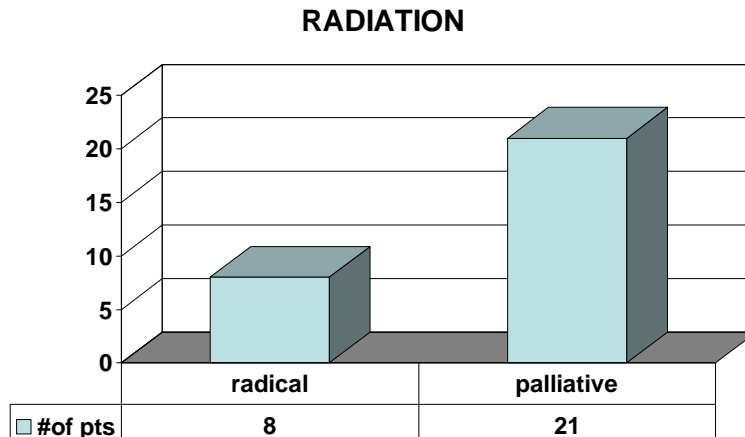


**RADIATION:**

29 of 73 patients had radiation at Norwalk Hospital and their complete records were available. The remaining patients did not undergo radiation and in a handful this information was not available if they had treatments elsewhere. 25 of the 73 patients were recorded as undergoing chemotherapy. 48 patients either did not undergo chemotherapy as initial management of their lung cancer or the information was unknown.

11 patients had stage IIIA or IIIB disease, a stage when radiation is used for radical treatment with intent to cure. Our data indicates that 8 patients underwent radiation treatment receiving a dose between 5940 and 6660 cGy

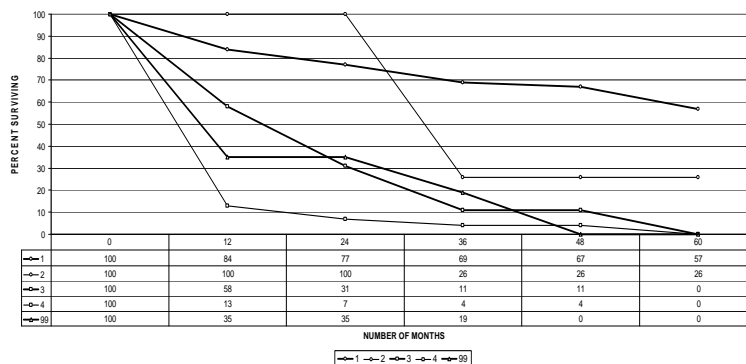
mostly concomitantly with chemotherapy. Some of the stage III patients did not undergo radical radiation but only palliative radiation was delivered as their performance status was too poor. 32 patients presented with metastatic disease. 21 of them underwent palliative radiation in addition to their chemotherapy. The most common sites of treatment were for brain metastases and bone metastases. A patient presenting with superior vena caval obstruction also underwent palliative radiation with chemotherapy.



**CHEMOTHERAPY:** The majority of patients with stage III disease underwent combination chemotherapy. Most patients had platinum based doublets -either CarboPlatinum and Taxol with radiation or CisPlatinum and Gemcitabine. Patients presenting with metastatic disease had a variety of chemotherapy agents proceeding from first line to second line with drugs including Methotrexate, Etoposide, Taxotere and Navelbine. Clinical trials studying Iressa and other novel agents were also available during this time. Over 60 patients have received Iressa at Norwalk Hospital as part of a compassionate clinical trial.

**OUTCOME:** By 2006, all patients had a minimum of 5 year follow up and therefore survival was actual rather than projected or actuarial. The relative survival for stage I patients was 57%, for stage II it was 26%. The three year relative survival of patients with unknown stage was 19%, stage III 11% and stage IV 4%. There were only 4 patients with Stage II disease, their staging was clinical in 2 and therefore the survival curves are skewed. Our overall survival mirrors the experience of other large centers.

RELATIVE SURV BEST AJCC STAGE  
NON-SMALL CELL SURVIVAL 2001



## DISCUSSION

Non small cell lung cancer accounts for approximately 87% of lung cancers. One half to two thirds are adenocarcinomas and approximately one third are squamous cell carcinomas or of other histology. Small cell lung cancer makes up about 13% of all lung cancers. Squamous cell cancers tend to be of central presentation, have a greater propensity for local persistence and are relatively more common in men. Adenocarcinomas are often more peripheral and have a higher incidence of metastases and are often seen in non smokers.

**SURGERY:** The morbidity of a full thoracotomy to be performed for even a lobectomy has been decreased by newer techniques like sleeve resection and other lung parenchyma sparing resections. The use of video assisted thoracoscopic lobectomy has increased. The pleural space can be more completely evaluated and addressed with this VATS. It enables the surgeon to assess suitability of patients for radical resection. Although PET/CT scans show a very high degree of specificity, there continue to be false positives and before such patients are deprived of potentially curative resection, the patients undergo mediastinoscopy and mediastinotomy. RFA is another technique being explored for patients unable to undergo surgery or with unresectable disease. Stereotactic radiosurgery is yet another option for such patients.

**RADIATION:** Radiation techniques have now become more selective for tumor destruction and normal tissue sparing. The IMRT techniques which were first applied to organs with limited motility like prostate or gynecological tumors could not be applied to lung cancers where the respiratory motion would move the tumor in and out of the beam. With the advent of imaged guidance capability in the latest linear accelerators and the ability to

do respiratory gating we will now be able to use even smaller radiation beams and turn the beam on only during the phase when they are in the radiation path. In the present study there were no grade III or IV radiation toxicities encountered.

**CHEMOTHERAPY:** Prior to 2003 first line treatment for good performance status patients with advanced non small cell lung cancer was platinum based doublets. Single agent treatments were used for the elderly. Four to six cycles were the standard. Second line treatment was Docetaxel and third line treatment was Gefitinib.

Evidence based medicine in 2008 would suggest first line treatment for advanced non small cell carcinoma of the lung to include platinum doublets, possibly with the addition of Bevacizumab. Second line treatment is Docetaxol, Pemetrexed and Erlotinib.

Prior to 2004, non small cell lung cancers were often classified as epithelial cancers, not otherwise specified. Today it is increasingly important to separate the squamous from the non squamous cancers as the squamous cell cancers have a better outcome with Gemcitabine or IGFRMabs and the adenocarcinoma do better with EGFR TKIs (Erlotinib, Gefitinib) and Pemetrexed.

Patients with squamous cell cancers with large central lesions have a higher risk of fatal hemorrhage with Bevacizumab. Platinum based doublets followed by Gefitinib has improved progression free survival and overall survival in adenocarcinomas. Non smoker's median survival was longer than 20 months.

Pemetrexed is a multi targeted anti-Folate with broad spectrum of activity. It inhibits Thymidine and other Folate dependant enzymes. Squamous cell cancers have a higher baseline expression of TS gene and protein and show reduced sensitivity to Pemetrexed.

**STAGING:** Staging is a high priority for the American College of Surgeons goals for the year 2009. The staging of lung cancer was based on Mountain's data which is over 25 years old. After several meetings and evaluation of thousands of patients on hundreds of clinical trials, the AJCCS and the UICC will be coming out with a new staging system for lung cancers for 2009. As the prognosis for patients with tumor nodules in the other lobes in the contra lateral lung (so far a T4 designation) is not much different than T3, they will be moved to the T3 designation. Similarly at present, if there are tumor nodules in other lobes, it was considered M1. This has now been moved to the T4 category. Patients with tumor nodules in the contra lateral lung will now be designated as M1A as also those with malignant pleural effusion (no longer to be considered as T4). The M1B staging will be for patients with distant metastases who have a median survival of 6 months.

Proposed TNM staging changes for lung cancer in 2009:

T1A  $\leq$  2 cm  
T1B  $> 2 \leq 3$  cm

T2A  $> 3, \leq 5$  cm  
T2B  $>5, \leq 7$  cm

T3  $> 7$  cm

#### **STAGE GROUPING**

	N0	N1	N2	N3
T1A & T1B	IA	IIA	IIIA	IIIB
T2A&T2B	IB	IIB	IIIA	IIIB
T3	IIB	IIIA	IIIA	IIIB

### Reported 5 year Survival (Various Sources)

Stage I            60-76%  
Stage II 50%

cN0                42%  
cN1                29%  
cN2                16%  
cN3                7%

The national averages for 5 year survival for stage I is 60-76%, stage II is 50%, stage III/N1 29%, N2 16% and N3 7%.

### **CONCLUSION**

Efforts need to be continued to prevent lung cancer by not smoking and to diagnose patients at earlier stage. The value of screening CT scans continues to be debated. Even patients with stage IA (T1N0) non small cell lung cancer have a one in four chance of recurrence. Two thirds of the patients with stage IIIA (N2) will die of their disease. Therefore adjuvant therapy is important in nearly all of the cancer patients and these patients should be evaluated by medical and radiation oncologists as early as possible in the treatment plan. The weekly hospital Tumor Board is an excellent venue for such discussions and will ensure optimal cancer care.

The author acknowledges the excellent assistance of Ms. Patricia Tersigni, Lead Tumor Registrar for her help in preparing for this manuscript.

# Lung Cancer PCE follow up

10/05/08

## Lung Ca at NH in 2001

80 of 826 diagnoses were Lung Cancer  
35 males and 38 females with NSCLC

Stage I	27 %
Stage II	5 %
Stage III	15 %
Stage IV	44 %

# Pulmonary Tumors in Netherland

Thorax, 2008 Aug 4, deJong WK

135,000 cases 1989-2003

Stage shift with fewer St I and more

	St IV
SCC	25%
Adeno	44%
Large cell	49%

## Stage Migration

- Better diagnostic procedures including mediastinoscopy, mediastinotomy, VATS
- Better radiological studies, CT, bone scans, PET/CT, Brain MRI
- Patients originally thought to have St I and II and III, were found to have actually St IV disease after modern day w/u.
- Explains high % of St IV in Norwalk series.