An Ounce of Prevention…

Can Offer a Lifetime of Health

The GBMC Cancer Center will host the following programs and screenings in 2008:

**LUNG CANCER EARLY DIAGNOSIS PROGRAM**

February 9  May 10  August 9  November 8

Open to individuals ages 40 to 80 years who are current or past smokers with a pack per day history for 10 years or the equivalent. Screenings are conducted from 8:00 a.m. – 12:00 noon and are held at the Advanced Radiology Center in Physicians Pavilion North I – 6535 North Charles Street, Suite 100.

**PROSTATE SCREENINGS**

February 26  March 4  March 18  April 8  May 6  June 3

September 23  October 21  November 18

The American Cancer Society recommends that men who have a family history of prostate cancer or who are African American should begin yearly screenings at age 40. All other men should begin annual screenings at age 50.

**VOICE SCREENINGS**

Held on the fourth Thursday of each month from 3:00 p.m. – 5:00 p.m. in the Milton J. Dance Jr., Head and Neck Rehabilitation Center, Physicians Pavilion West.

**ORAL SCREENINGS**

November 18  5:00 p.m. – 6:00 p.m.

Prostate, skin and oral cancer screenings are held in the Radiation Oncology lobby in GBMC’s main hospital building.

Pre-registration is required for all screenings by calling 443-849-3080. For Voice Screenings, call 443-849-2087 to register.
Fiscal Year 2007 Annual Report (Using 2006 Cancer Registry Data)
FROM THE DIRECTOR

Dear Colleagues and Friends of GBMC’s Cancer Center,

As you read through this annual report issue of Greater Oncology Today, you will notice a recurring theme that has taken hold of GBMC’s Cancer Center—growth. Over the past year, the Center has added new research protocols to its roster of important clinical trials; introduced a patient navigator who provides guidance and friendship and brings a personal touch to patient care during the treatment and healing process; has witnessed cutting-edge technology and new, lifesaving procedures by dedicated and dynamic surgeons; and has seen an increase in the number of patients who have been educated by taking part in the breast cancer risk assessment program. Additionally, we are experiencing the major expansion of the Dance Center, both in physical space and in services and outreach to the community.

While positive change is certainly in the air at the Cancer Center, one fact remains constant—patient satisfaction is paramount. The establishment of a new Patient and Family Advisory Council and an interdisciplinary patient satisfaction task force allows us to continue to focus our attention and human resources on improving the outpatient and inpatient experience.

As you turn the pages of this issue, take note of how patients like Kimberly Wright have turned a life-altering battle with breast cancer into a life-enhancing journey, and how the entire cancer center staff, from surgeons and medical oncologists to nurse specialists and the cancer registry team, continues to commit themselves to making a positive impact on the lives of our patients and families every day.

Warm wishes for this holiday season,

Gary I. Cohen, MD
Director of the Cancer Center at GBMC
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GBMC CANCER CENTER PROFILE

Founded: 1990  Director: Gary I. Cohen, MD

Area Focuses
Breast: Sandra and Malcolm Berman
Comprehensive Breast Care Center
Head and Neck: Milton J. Dance Jr., Head and Neck Rehabilitation Center

Cancer Control/Community Outreach
Year-round cancer screenings to detect lung, prostate, skin and oral cancers.

Patient Services
Support Programs: John M. McGovern, MD, Oncology Support Program; The Boutique
Joseph S. Keelty Inpatient Oncology Care Unit (34)
Sheila K. Riggs Radiation Oncology Department
Lois Harvey Miller Infusion Therapy Center
The Division of Gynecologic Oncology
Active participation in an array of cancer research trials for prevention, treatment and symptom management
The Cancer Registry is an integral part of the cancer program at GBMC and vital in our relationship with the Commission on Cancer (CoC). In 1956, the CoC provided impetus for the development of hospital-based registries by incorporating the maintenance of a hospital-wide cancer registry into their requirements for an approved cancer program. In October 1992, Congress established a National Program of Cancer Registries. This legislation authorizes the Centers for Disease Control and Prevention (CDC) to provide funds to states and territories to enhance existing cancer registries and to plan and implement registries where they do not exist. The CoC, originally a joint venture of the American College of Surgeons and the American Cancer Society, was expanded in 1965 to include members from other organizations involved in cancer care. Forty-four (44) additional members represent organizations involved in the care of the cancer patient—the National Cancer Registrars Association (NCRA) is one of the 44.

The Cancer Registry is responsible for the collection, management and analysis of data on cancer patients. An abstract is compiled on each cancer patient based on a review of the medical records including pathology reports, operative reports, radiology reports, physician notes and other treatment reports such as chemotherapy and radiation therapy. Other patient demographics and long-term follow-up survival data is collected. This data is reported to the Maryland Department of Health and Mental Hygiene as well as to the National Cancer Data Base (NCDB) of the CoC. Individual patient identity is kept strictly confidential.

GBMC has released its latest data to the NCDB, which can be viewed on the American Cancer Society’s website (www.cancer.org). From the starting date of January 1, 1990 through December 31, 2006, the Cancer Registry has abstracted 32,546 cancer cases. GBMC’s follow-up rate is 98 percent.

In addition to collecting cancer-related data, the cancer registry performs a host of other activities. One of these activities includes analyzing and validating data that is reported to the NCDB and then presented back to the hospital in the form of patient quality of care assessments. Recent reviews have included a Cancer Program Practice Profile Report (CP3R) on the use of adjuvant chemotherapy for Stage III colon cancer and an electronic Quality Improvement Package (eQuIP) for breast cancer.

Another endeavor undertaken by the Cancer Registry is to develop an electronic staging form that allows physicians to TNM stage a new cancer and then sign off electronically on the hospital’s Meditech computer system. This project, undertaken by Cleveland Sigh of GBMC’s Cancer Registry and the IT department, has allowed the physicians to timely stage their patients and keep us well within the guidelines mandated by the CoC.

Three full-time and one part-time Certified Tumor Registrars and a part-time follow-up clerk staff the Cancer Registry at GBMC (see article on page 10). Their efforts are greatly valued by the Cancer Program at GBMC and the Commission on Cancer.
As part of its ongoing effort to offer patients the largest spectrum of clinical trials options, the GBMC Cancer Center has long been a member of the Cancer Trials Support Unit, or CTSU. The National Cancer Institute (NCI)-sponsored group provides clinicians across the country with improved access to NCI-sponsored Cooperative Group phase III adult treatment trials.

Previously, GBMC was limited to trials conducted by specific cooperative groups, such as the Eastern Cooperative Oncology Group, known as ECOG, or to specific intergroup trials supported by those cooperative groups in which they were members, explains Lauren Titus, CCRP, Clinical Research Coordinator. “CTSU provides important access to clinical trials across the board, making it easier for us to participate in studies conducted by groups in which we are not members.”

With access to many investigational studies within multiple Cooperative Groups, GBMC and its patients benefit. “We can provide our patients with many more trials than before,” Ms. Titus says. Typically, the Cancer Center has some 55 active studies underway. Currently, a handful of them are being conducted through the CTSU, including trials for head and neck, gastric, colon and gynecologic cancer.

Further, this approach creates a centralized location for investigators to submit regulatory documents, enroll patients and access study documents. “With the help of CTSU and the Central Institutional Review Board (CIRB), we can open protocols faster and streamline the processing of our trials,” Ms. Titus adds. CTSU provides such services as regulatory support, patient registration, clinical data management, help desk support and education and training. Another key advantage of the CTSU is our ability to activate new studies, literally within days of approval by NCI, rather then several months, as in the past.

CTSU was launched in 1999 to provide clinicians across the United States and Canada with improved access to cancer treatment trials. Today, CTSU is a vital part of the Cooperative Group system responsible for conducting most of NCI’s phase III treatment trials.

In addition to Ms. Titus, the GBMC clinical trials department has three other clinical research associates and one nurse. Treatment is overseen by a team of five medical oncologists, as well as surgeons or radiation oncologists, as needed.

“As the science of treating cancer grows exponentially, having access to a wealth of studies solidifies GBMC’s reputation in the community,” says Cancer Center Director Gary I. Cohen, MD. “Broad participation and rapid accrual within these studies across the country lead to achieving study results much faster than was possible before the group was formed.”
BMC recently enhanced the support services available for cancer patients with the addition of a new and unique resource—the American Cancer Society (ACS) Patient Navigator. In this new role, Patient Navigator Mindy Shifflett spends each day talking with patients in the infusion center, informing them of the many support services available through the hospital and other resources.

“One of the great benefits of having a Patient Navigator is that she is completely devoted to discovering what patients’ specific needs are and helping them connect with services that fulfill those needs,” says GBMC Medical Oncologist Robert B. Donegan, MD. “Because she is in continual contact with patients and can focus on their psycho-social condition, Mindy is more likely to identify those needs before they become a problem. The support she provides is an enhancement of what we as physicians, nurses and medical staff do.”

GBMC is the first hospital in Baltimore County to incorporate the ACS Patient Navigator Program into its Oncology Support Program. Before coming to GBMC, Ms. Shifflett worked as a cancer information specialist in the ACS’ Cancer Resource Network. She also notes a personal reason for her commitment. She saw first-hand the ups and downs of a family member who battled cancer and, she feels strongly, “no one should have to go through this alone. I’m there to help ease the challenges so patients can focus on getting well.”

**A True Partnership**

Dr. Donegan describes his relationship with Ms. Shifflett as a partnership. He and his staff have identified patients who could benefit from her support and passed the information on to her. She, in turn, has discovered patients who have not mentioned their concerns to their physicians and has shared that information with the medical staff while finding support services to help address those patients’ needs.

“But not only does Mindy provide a connection to oncology support resources, she is also a friendly presence in the infusion center, someone they can talk to about substantive issues or just have a chat with,” adds Dr. Donegan. “A huge part of clinical care is in the customer service we deliver. It’s not just response rates and medications—there is an ancillary, softer side we respond to by providing support and resources for patients and their families. The patient navigator fills that role quite well, boosting the quality and breadth of service we provide.”

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Learn more about the patient navigator program—call 443-849-2961.

Mindy Shifflett helps patient Colette Nichols with information about medical insurance, disability and Catastrophic Health Planners to help with financial matters.
PATIENT EXPERIENCE

From Breast Cancer Patient to Survivor and Advocate—One Woman’s Story

It was New Year’s Eve 1994. Kim Wright, then 36, her husband and two-year-old daughter would enjoy a quiet holiday together over Chinese food. A quick shower before the family festivities were to begin would change Kim’s life forever. She felt a large and solid mass in her right breast. She recalls, “I was stunned. I just could not believe it.”

Her Journey to Survivorship

She immediately went to her gynecologist to have this suspicious mass examined. And so began the series of events that would forever change Kim’s life. The next several Fridays were a whirlwind of tests and procedures to confirm Kim’s worst fears. And, along the way, she found out she was pregnant. “I just wanted to be done with the uncertainty and get on with this new and welcome pregnancy.” Yet, life was to throw Kim a curve ball.

“It was explained to me that I would need to have surgery and probably treatment. My doctor would be sending me to a good surgeon. I asked then about the baby. She looked at me for a minute and then quietly said I would not be able to continue the pregnancy. That was when I lost it. I was inconsolable,” recalls Kim in a blog entry she wrote about her experiences.

In the end, Kim says, “The decision to move forward with the surgery and treatment was not a hard one. I had to be there for my two-year-old daughter. I never wanted her to wonder why she was not enough and what took me away from her.”

A New Life Mission

The rest, as they say, is history. Kim’s final treatment was July 3, 1995. She was cancer-free. Since then, she has been a very active advocate for Susan G. Komen for the Cure. Kim has volunteered hundreds of hours with the organization in a multitude of capacities, serving as an advocate reviewer of grants on a local and national level, as survivor chair for the Maryland Race for the Cure and graduating from Project LEAD. Kim is also a recipient of half a dozen awards from the organization throughout the years.

“I am an assisted reproductive technologist by trade, but breast cancer advocacy is my life’s work!” says Kim, who has involved her now 15-year-old daughter in many of her efforts. “I can honestly say that breast cancer has changed the course of my life. It has made me who I am today and helped me understand that you need to be an advocate for yourself.”

In addition to the love and support of her family, Kim credits her team of GBMC physicians for her survival, including Ginny Merryman, MD, OB/GYN, Gary Cohen, MD, medical oncologist, Frank Rotolo, MD, surgeon and Robert Brookland, MD, radiation therapy.

“I am now a 12-year survivor and going strong,” she proudly states. “I do have to say though, that to this day, I am not very fond of Chinese food.”
In 2006, GBMC introduced a new tool for women who wanted to identify an increased risk for developing breast cancer. The Breast Cancer Risk Assessment Program, directed by Scott E. Maizel, MD, FACS, offers women an opportunity to receive an objective, accurate assessment of their actual individual risk of developing the disease.

“Our program has continued to grow over the past year,” notes Dr. Maizel. “I have seen many women who come to us because their mother had breast cancer and they are worried about what the future might hold for them. The majority of our patients have been determined not to be at increased risk for breast cancer, while only five to 10 percent have had an identifiable genetic risk. That lines up with the statistics we expected to see when we started the program last year.”

The program is available at GBMC’s Sandra and Malcolm Berman Comprehensive Breast Care Center and it incorporates the latest computer risk assessment tools. The assessment includes a detailed personal and family medical history, which the patient enters into a handheld computer system developed by researchers at Harvard University. That program will be enhanced in the coming months when the Gail model for risk assessment is incorporated into the program to screen for an even wider range of risk factors.

Dr. Maizel’s patients have included women of all ages as well as some men. Laura Crovo, a 28-year-old Parkville resident, was referred to the program by her primary care provider.

“My mother had breast cancer when I was four years old,” she explains. “She was only 34 when she was diagnosed and is now a 24-year survivor. Because of her experience, and the fact that we are very involved with events like the Race for the Cure, education and prevention are very important to me.” She adds, “I was concerned that I was at an increased risk for breast cancer because of my mother’s history, but I was relieved to learn that my actual risk falls within the normal range. It’s good to know the cards are not stacked against me.”

Bethany Jakubowski heard about the program from her family doctor in Bel Air. Because the 23-year-old’s mother is a seven-year breast cancer survivor, she is vigilant about performing monthly breast self-exams. When she discovered what she thought was a lump,
Dr. Maizel examined her and determined the finding was of no concern. During this visit, Ms. Jakubowski also completed the assessment tool. “My mom encouraged me to have the assessment,” she explains. “When I learned that I was not at an increased risk for breast cancer, I felt a lot better and so did my mom. I talked with Dr. Maizel about what preventive steps I should take and I feel like I’m doing what I can to stay healthy.”

Another patient, Cheryl Bosse from Finksburg, has a strong history of breast cancer. Both her mother and her grandmother had breast cancer and the disease claimed her mother’s life. “My goal is to do all I can in terms of early detection and prevention,” the 48-year-old Ms. Bosse says. “I want to take all the precautions I can, especially since I’ve had several breast cysts over the years and because of my family history.”

For patients who do have suspicious findings on their mammogram or physical exam, the program offers a rapid diagnosis fast track. Dr. Maizel points to a recent patient with an abnormal mammogram whom he saw at 11:00 a.m. and who had her biopsy performed at 1:00 p.m. that same day.

“The goal of all the services we deliver through the program is to provide our patients with an accurate picture of their risk,” he adds. “We put their fears in perspective and empower patients with objective information and a plan to manage their risk.”

To refer a patient for an assessment, contact the Breast Cancer Risk Assessment Program at GBMC at 443-849-2600.

“Dr. Scott Maizel reviews results of a patient’s risk assessment based on the answers she provided about her personal and family medical history.

“We put their fears in perspective and empower patients with objective information and a plan to manage their risk.”

Scott E. Maizel, MD
Think of GBMC’s cancer registrars as private investigators—constantly tracking down individuals and pertinent data. Three full-time registrars and a part-time clerk actively follow 16,000 of the 32,000 total GBMC cancer patients, coding all aspects of care—demographics, diagnostics, pathology and laboratory reports, and complete treatment—into a central database. Coordinator Sharon McIntire, MA, CTR, attests that maintaining accurate records requires some detective work. Patients often receive multimodal treatments at different facilities, and the registry staff must code all treatment and document the treating physicians for each patient in the database. “The Cancer Registry follows all GBMC cancer patients for their lifetimes, even if they are in remission or have moved out of state,” she explains. Active patient files are updated annually, starting with letters to the patients and, if they do not respond, calls to the physicians. “It’s a lot of work to keep track of everyone, because as patients move and/or change doctors, we have to be vigilant about updating the database.”

Why Collect Data?

The data collected by GBMC’s registrars is reported annually to the Maryland Department of Health and Mental Hygiene’s Maryland Cancer Registry (MCR) and the National Cancer Data Base (NCDB) in Chicago. These organizations use the raw data to compile statistics on survival, diagnosis and treatment successes and to compare local and national trends. Additionally, the Registry compiles a five-year survival study that compares GBMC’s survival statistics for one cancer type to the national data (by stage at diagnosis). An operational cancer registry is also a requirement for cancer programs to be approved by The American College of Surgeons’ Commission on Cancer.

Hard Work Worth the Effort

A common desire to help people motivates the team to continue searching for patients and to strive for more accurate information. “We gather and organize many small pieces of patient information,” Cleveland Sigh, BA, CTR, notes. “If we miss one element, the statistics will be skewed.” But, as Brian Schexnayder, BS, CTR, points out, “When all the details come together, they create a bigger picture about an instance of cancer, which can then be used to help others.”

“It can be difficult to get the data we need,” adds Patricia Sowinski. “People often don’t understand why GBMC is calling when they haven’t been treated here in years. Taking time to explain the Registry’s purpose makes all the difference.” It’s all a part of the investigative process that pays off when the National Cancer Data Base can offer patients more precise statistics regarding their healthcare options.
For people suffering with cancer, oncology nurses are important allies. Their broad knowledge base impacts countless aspects of cancer care including detection, education, surgery, medical treatments and management of side effects. Nurses dedicated to the field of oncology seek certification by the Oncology Nursing Certification Corporation (ONCC), which requires independent study as well as continuing education during employment. These generalists in cancer care treat patients’ physical and emotional needs, administering chemotherapy or radiation therapy, offering suggestions for controlling symptoms and preparing people for what to expect over the course of their treatments. GBMC has nearly 20 such nurses on staff, with several studying for the certification exam.

“Patients can benefit greatly from the care of a certified oncology nurse,” notes Dawn Stefanik, AA, MLT, BSN, RN, OCN, GBMC’s Clinical Manager of Infusion Therapy and oncology certified nurse. “We keep abreast of available treatment options, new cancer medications and procedures, emerging research results and clinical trials that may be valuable for our patients, many of whom cross several areas of oncology during their treatments,” Ms. Stefanik adds. “We help them participate in their own care.”

A Passion for Caring

Oncology nurses are passionate about their jobs for two reasons: the rewarding relationships they develop with patients and their families and the stimulating challenge of maintaining expertise in the various areas of cancer. Both of those reasons attracted Paula Schaffer, RN, BSN, OCN, Nurse Manager for GBMC’s inpatient oncology unit, to the field in 1988. “I wanted, and still want, to make a difference in people’s lives, while allowing myself the opportunity to grow with my profession,” explains Paula.

“I always thought I would work in the neonatal nursery,” admits Katherine Lober, RN, who worked on the oncology unit and in infusion therapy before moving to the newborn nursery to care for babies. She quickly realized that it wasn’t her calling after all. “Oncology nursing is what I love and where I belong,” she comments. “Working in oncology allows me to make a positive impact on people during vulnerable stages in their lives, which gives me a lot of satisfaction.”

Ms. Schaffer adds that the job can be emotionally stressful at times, but that it’s worth the effort when survivors come back to visit. “People remember what you did for them, and how you helped their families through difficult situations,” she says. “It’s the best feeling in the world.”

Dawn Stefanik (center) and Katherine Lober (left) tend to a patient in the Infusion Therapy Center.
In 1980, the concept of addressing the physical and psychosocial needs of head and neck cancer patients was new. Only through the vision of late benefactors Milton J. Dance, Jr., a former patient, and his wife Jeanne Vance, did GBMC’s Milton J. Dance, Jr., Head and Neck rehabilitation program come to fruition. For the past 27 years, the Milton J. Dance Jr. Endowment, Inc. has sponsored the work of the Center, providing comprehensive care and support to patients and families. Their generosity continues to make a difference today. The endowment will help fund the Center’s newest phase—one that will triple the physical space, provide for additional programming and bolster research.

**New Facility in 2008**

At 3,000 square feet, the current Dance Center is bursting at the seams. The Center saw nearly 192 new head and neck cancer patients during the last fiscal year, as well as numerous patients in the follow-up phase of their rehabilitation. Overall, last fiscal year, the staff provided over 3,100 inpatient and outpatient.
evaluation and treatment services to cancer and non-cancer patients of all ages.

To accommodate current and future demand, in fall 2008 the Dance Center will relocate into a new suite on the fourth floor of Physicians Pavilion West. At nearly three times the size—11,000 square feet—the specially designed area will have more treatment rooms, larger waiting areas and additional space for new programs and services.

“The expansion allows us to provide services with a higher level of patient comfort and convenience,” says Barbara Messing, MA, CCC-SLP, BRS-S, Clinical Director of the Dance Center. It supports our work, our staff, our research efforts and our state-of-the-art technology.”

One of the many exciting changes on the horizon is the expansion of the existing voice program to treat the wide-range of diseases and disorders that may cause problems with the structure and function of the larynx (voice box). “By working in collaboration with Johns Hopkins, the Dance Center will expand its voice program and establish a world-renowned program, housed at GBMC, for laryngeal surgery and voice rehabilitation,” says Dance Center Medical Director John Saunders, MD, who also serves as GBMC’s Chief of Staff.

“We will manage all types of laryngeal voice problems including benign and malignant lesions, neurological disorders and vocal dysfunction due to behavioral causes,” Dr. Saunders explains. The collaboration will also include state-of-the-art medical and surgical management of throat disorders including specialized microsurgery to address voice issues.

Physically, the new space will make it easier to see patients, says Melissa Walker, MS, CCC-SLP, speech pathology coordinator. “We are blessed as a Center to have the newest technology, but it’s hard to use everything in small quarters,” she adds. “Now, we will have the room to spread out. It’s an outstanding opportunity.”

Karen Ulmer, BSN, RN, CORLN, agrees. “As we have progressed over the years, we have added people and programs. This new facility will be extremely patient-friendly, making it easier for us to provide care.” Ms. Ulmer is enthused about the planned patient resource library, which will provide information about treatment, research and support for patients. “We look forward to continued outreach in the community. The new Center helps us fulfill our mission.”

“The growth of the Dance Center has brought with it higher volumes of patients with head and neck cancers,” adds Dorothy Gold, LCSW-C, OSW-C. “I have seen greater and more complex psychosocial issues, both emotional and practical, that can impact on the success of any treatment. We are now looking forward to adding a second social worker to our staff, which will enable us to better serve our patients and their families.” Other staff members to be added include a Johns Hopkins/GBMC laryngologist, registered dietician and speech pathologist/voice specialist.

Evidence-Based Research Underway

When the Center was founded, research into head and neck cancer was in its infancy. Today, research is a critical component. Certainly, GBMC’s longstanding relationship with Johns Hopkins drives progress. “We can further our participation in clinical research by working closely with Hopkins,” says Dr. Saunders. “This entails us now being able to enroll patients in research such as the HPV vaccine-
related trials, and having the resources to manage it. We will also continue molecular genetic research on patients who have head and neck cancer. The abnormalities in the DNA promote the cancer.”

Recently, GBMC’s Institutional Review Board approved two research endeavors: “The Efficacy of Prophylactic Swallow Interventions in the Head and Neck Cancer Patient Undergoing Organ Preservation Cancer Treatment,” and “Candida Prophylaxis for Alaryngeal Patients with Voice Prostheses.” New research projects are already in the planning process.

Vision for the Future
In just the past few years, there have been enormous changes in the treatment of head and neck cancers. The most significant change has been the organ preservation protocol known as the Brizel technique, using a regimen of concurrent chemotherapy and twice-daily radiotherapy, lessening the need for surgical intervention. “Organ preservation protocols reduce the number of extensive surgeries and reconstructions from head and neck cancer, although in some cases surgical interventions are necessary,” says Ms. Messing. “Chemotherapy and radiotherapy have changed the outcome of head and neck cancer patients, but there is still significant impact on speech and swallowing function, important indicators of quality of life.”

Another development is the discovered link between the HPV virus and head and neck cancers. “These patients are often younger, with children and with many financial responsibilities,” says Messing. “We work together to help them manage the many life-changing aspects of the cancer and treatment side effects.”

As the treatment of head and neck cancer and other disorders continues to evolve, the Center is committed to remaining at the forefront. “The Dance Center is known for its clinical expertise and specialization,” says Brian McCagh, Executive Director, Oncology Services. “These clinical experts have a magnetic pull in our community.”

“This is indeed an exciting time of change and growth as the Dance Center prepares to enhance its reputation as the premier interdisciplinary head and neck cancer and voice center,” Ms. Messing adds. “As a team, we will continue to strive for excellence through partnership and collaboration, and always maintain that at the Milton J. Dance, Jr. Head and Neck Center, the patient comes first.”

“The expansion allows us to provide services with a higher level of comfort and convenience. It supports our work, our staff, our research efforts and our state-of-the-art technology.”

Barbara Messing, Clinical Director of the Milton J. Dance Jr., Head and Neck Rehabilitation Center
HEAd AND NECK CANCER

GBMC Physician Addresses Salivary Gland Cancers, Introduces Laser Technique for Early Glottic Cancer

As an employee and trainee of the Johns Hopkins Department of Otolaryngology, Patrick Ha, MD, knew of GBMC’s reputation in head and neck cancer from the start, making it a win-win for him to join Greater Baltimore Head & Neck Associates as a member of the head and neck surgery team. “The Center’s clinical work is at a high level and has tremendous experience with patients who have head and neck cancer. Truly, this is a great place to work and begin my career.”

Intrigued by cancers of the salivary glands, Dr. Ha’s clinical and research work is focused on this “underserved and under-researched group of cancers.” Of head and neck cancers, he notes, only five percent attack the salivary glands. Within this small number, however, there are 30 to 40 different types of tumors that can affect the salivary glands.

“Each tumor behaves differently with regard to aggressiveness, metastatic potential, and outcome. From a molecular standpoint, these are unusual tumors to study,” he says. For example, certain salivary gland cancers that have metastasized may not necessarily shorten the lifespan. Furthermore, many salivary gland malignancies may not be linked to smoking. It is these mechanisms of disease that he is studying through an NIH-funded research grant.

“The disease has very good survival rates if caught early. About 80 percent of salivary gland tumors are benign. The other 20 percent are treatable with surgery and post-operative radiation therapy.”

The team approach at the Dance Center is an ideal environment for patient care and research pursuits, states Dr. Ha, who also maintains a dual appointment with the Johns Hopkins Department of Otolaryngology, where his research lab is located.

Lasers Attack Early Glottic Cancer

Another effort by Dr. Ha is the use of lasers for early glottic cancers, an approach called transoral laser surgery.
Instead of making an incision in the neck as with traditional surgery, this technique allows the surgeon to use an endoscope to visualize the larynx. The surgeon focuses a carbon dioxide laser beam to excise the cancer, sparing nearby healthy tissue. Patients return home within one to two days, versus a week with traditional surgery. They also realize decreased discomfort, less scarring and a faster recovery. There are improved aesthetic and functional outcomes, and these techniques offer similar survival rates to more traditional surgery or radiation therapy.

This new technique represents an alternative to surgery for many patients, although individuals who have large tumors or tumors that are inaccessible may not be suitable candidates.

“We can pick and choose which approach is best based on the patient’s needs,” Dr. Ha explains.

For patients for whom transoral laser surgery is not the ideal option, a combination of open surgery, radiation therapy and chemotherapy is often effective, he notes.

“Previously, radiation therapy was not as sophisticated as today’s approach, necessitating reliance on surgery. Now, radiotherapy is established firmly as a complement or alternative to surgery in many cases.

“There isn’t always a clear-cut answer. Our goal is to offer options that best serve the patient,” says Dr. Ha.
A “SHERO” Among Us

Barbara Raksin, RN, was one of 38 women recognized as a super woman of Maryland at the first annual SHERO Awards in October. The SHERO Award celebrates women and their impact on the local community and those who, through their time and contributions, have touched the lives of others. Funds raised through the event benefit the SHERO Scholarship fund.

An excerpt from Barbara’s nomination states, “Barbara is an inspiration to all who know her for the way she lives her life – dealing with her personal battle with breast cancer, yet still working and volunteering to help others. She has helped countless women through the Sandra and Malcolm Berman Comprehensive Breast Care Center face their own diagnosis…”

For more than a decade, Barbara has been very active with Susan G. Komen for the Cure, volunteering innumerable hours for Race for the Cure and serving as Chair of the annual educational symposium.

“This is truly an honor and was a great evening for me,” says Barbara. She adds, “Having gone through the diagnosis and treatment of breast cancer myself now helps me relate even more to what my patients go through. My patients are my heroes.”

New Executive Director to Lead Cancer Center

Brian McCagh has been named Executive Director of Oncology Services at GBMC, bringing more than three decades of experience to GBMC’s Cancer Center. Mr. McCagh had been serving as Interim Director since May 2007. Along with Gary Cohen, MD, Medical Director of GBMC’s Cancer Center, Mr. McCagh is responsible for the leadership and direction of the oncology service line.

Mr. McCagh’s focus is on optimizing outpatient throughput, implementing an electronic medical record specific for oncology patients and planning renovations and expansions to oncology space. He has established an Oncology Patient & Family Advisory Council comprised of patients, caregivers and GBMC staff, which assesses patient needs across the cancer care continuum, evaluates how to improve patient care and enhance services, and is examining the development of a cancer patient guidebook.

Prior to joining GBMC, Mr. McCagh most recently served as Vice President of Oncology and Neurosciences at Washington Hospital Center. He has also held administrative and executive positions at Montgomery General Hospital, Laurel Regional Hospital and Prince George’s Medical Center; and with a healthcare consulting firm and a major managed care organization. He also served with the United States Army in Germany.
For many patients with bladder cancer, the disease has a high risk of recurrence. Approximately 30 percent of patients have muscle invasion at the time of diagnosis. Traditionally, these patients’ primary management option was radical open surgery. Now, these patients may be prime candidates for minimally invasive robotic bladder cancer surgery. In mid-June, GBMC surgeons were the first in Maryland to perform robotic bladder cancer surgery using the sophisticated da Vinci™ Surgical System. The technique allowed surgeon Benjamin Lowentritt, MD, along with surgeons David Goldstein, MD, and Sean Van Zijl, MD, all of Chesapeake Urology Associates, to remove the bladder, prostate and a large number of lymph nodes without a large abdominal incision. The patient, Mr. Jim Enfield, 57, of the Eastern shore of Maryland, was walking the next day and returned home within the week.

The procedure is a beneficial alternative to the gold standard of treatment, the open radical cystectomy, considered one of the most invasive surgeries urologists perform. This approach often results in an extensive incision, significant blood loss and scarring and a lengthy recovery time in the hospital and at home.

“Robotic surgery allows us to extend our capabilities in areas that were difficult to address previously,” says Dr. Lowentritt. Surgeons realize improved flexibility, increased range of motion and enhanced visualization. “We have the dexterity to work in smaller areas within the bony shell of the pelvis, while maintaining the goals of cancer removal.” Ultimately, the patient can benefit from less post-operative pain, less blood loss, less scarring, a shorter hospital stay and a faster return to daily activities. Of note, patients who have previous open bladder surgeries may not be suitable candidates because of the likelihood of scar tissue build-up.

“For those with high-grade aggressive neoplasm, even at Stage 1, this surgery may be indicated to prevent the disease from getting worse,” explains Dr. Lowentritt. In some 30 percent of surgeries, the disease is more invasive or advanced than previously thought. Some patients have lymph node involvement, necessitating a significant dissection in all patients for better prognosis and hopefully cure. Dr. Lowentritt adds that many

“When patients need additional therapies, we work closely with the oncologist to design an appropriate treatment plan of chemotherapy prior to and after surgery.”

Benjamin Lowentritt, MD
patients receive chemotherapy in advance and may require additional cycles after surgery. Mr. Enfield did not require pre- or post-surgical chemotherapy.

“When patients need additional therapies, we work closely with the oncologist to design an appropriate treatment plan of chemotherapy prior to and after surgery,” says Dr. Lowentritt.

**Bladder Reconstruction**

During the procedure, bladder reconstruction is accomplished one of two ways. The most common approach is an incontinent diversion in which the ureters are attached to a portion of the small intestine, and then brought through the abdominal wall as a conduit for the urine, ending in an abdominal stoma. A second approach utilizes a larger piece of the bowel and transforms it into a balloon-shaped sac that is stitched to the proximal end of the urethra. Ureters are stitched to the new bladder so that urine drains directly into it from the kidneys. Most people learn to pass urine through the urethra rather than needing to wear a stoma bag or use a catheter.

**Statistics**

There were almost 50,000 robotic surgeries performed worldwide in 2006; 229 were robotic cystectomies. By mid-2007, there were approximately 150 robotic cystectomies performed, with Dr. Lowentritt’s the first such case in Maryland. As of late summer, he has performed four robotic bladder cancer procedures. Striking some 63,000 people annually, bladder cancer is the fourth most common disease in men and the ninth most common disease in women.
The Cancer Data Management System/Cancer Registry collects data on all types of cancer diagnosed or treated in an institution and is one of the four major components of an approved cancer program. From the reference or starting date of January 1, 1990, through December 31, 2006, GBMC’s Cancer Registry has abstracted into its database the demographic, diagnostic, staging, treatment, and follow-up information on 32,546 cancer cases. To ensure accurate survival statistics, the Registry is required to follow these patients annually. GBMC’s follow-up rate is 98%.

All data are reported quarterly to the Maryland Cancer Registry (MCR), which is part of the Maryland Department of Health and Mental Hygiene, and annually to the National Cancer Database (NCDB), the data management system for hospitals and programs approved by the Commission on Cancer. Co-sponsored by the American Cancer Society and the American College of Surgeons, the NCDB uses submitted data for comparative studies that evaluate oncology care and provides a Benchmark Summary of Cancer Care and Survival in the United States. The Cancer Committee at the Greater Baltimore Medical Center authorized our facility’s 2005 data submission to the NCDB, which included site and stage data, to be posted to the American Cancer Society’s web site (www.cancer.org). This Facility Information Profile System (FIPS) allows patients to view the types of cancers diagnosed and treated at a particular facility and can help patients make more educated decisions about their cancer care.

The MCR uses data to evaluate incidence rates for the entire state, and compares data by region and county; they also participate in national studies. In addition to required reporting, the Cancer Registry at GBMC provides data for physician studies and educational conferences. The Maryland Cancer Registry, the National Cancer Database and the Greater Baltimore Medical Center support web sites.

One part-time and 3 full-time Certified Tumor Registrars and a part-time follow-up clerk staff the Cancer Registry at GBMC. For additional information, call 443-849-8063.

Analysis

The Cancer Registry accessioned 1,944 cases during calendar year 2006. Of these, 1,845 were analytic cases—those patients who were initially diagnosed at GBMC and/or received all or part of their first course of treatment at GBMC. The 99 non-analytic cases were initially diagnosed and treated at other facilities before referral to GBMC for additional treatment for recurrent disease or were initially diagnosed or treated at GBMC prior to January 1, 1990. Many of these non-analytic patients chose to be treated in one of the many clinical trials available at GBMC.

In 2006, the mean age at diagnosis for males at GBMC was 65.1; for females, it was 60.6.
The racial distribution of cases includes 83% Caucasian, 14.6% African-American, 2% Asian and 0.4% other. While 53.5% of patients diagnosed or treated at GBMC live in Baltimore County and 20.2% live in Baltimore City, patients come from 19 other Maryland counties, Pennsylvania, Delaware, and other states for treatment.

Site Distribution

Breast cancer continues to be the most frequently diagnosed and/or treated cancer at GBMC, with 551 analytic cases. The second most common cancer at GBMC is prostate with 205 analytics, followed by lung (181 analytics), colon/rectum (155 analytics), and thyroid (82 analytics). (Tables 1 and 2) The American Cancer Society’s Surveillance Research estimated that 25,870 new cancer cases would be diagnosed in Maryland in 2006. That same year, GBMC diagnosed and/or treated an increased number of cancers of the prostate (205 compared to 179 in 2005); lung (181 compared to 159 in 2005); esophagus (9 compared to 6 in 2005); and salivary gland (14 compared to 10 in 2005).

Staging

To help the physician evaluate the patient’s disease at diagnosis, estimate prognosis, guide treatment, evaluate therapy and access the results of early cancer detection, the American Joint Committee on Cancer (AJCC) has established a TNM Staging Classification based on the premise that cancers of similar sites and histologies share similar patterns of growth and extension. In the TNM

Table 1
GBMC Site Distribution
All Cases 2006

<table>
<thead>
<tr>
<th>Primary Site</th>
<th>Total Cases</th>
<th>Analytic</th>
<th>Non-Analytic</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENITOURINARY</td>
<td>334</td>
<td>311</td>
<td>23</td>
<td>300</td>
<td>34</td>
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<tr>
<td>Prostate</td>
<td>216</td>
<td>205</td>
<td>11</td>
<td>216</td>
<td>0</td>
</tr>
<tr>
<td>Renal</td>
<td>47</td>
<td>45</td>
<td>2</td>
<td>29</td>
<td>18</td>
</tr>
<tr>
<td>Bladder</td>
<td>55</td>
<td>49</td>
<td>6</td>
<td>43</td>
<td>12</td>
</tr>
<tr>
<td>Other GU</td>
<td>21</td>
<td>17</td>
<td>4</td>
<td>18</td>
<td>3</td>
</tr>
<tr>
<td>BREAST</td>
<td>566</td>
<td>551</td>
<td>15</td>
<td>4</td>
<td>562</td>
</tr>
<tr>
<td>GASTROINTESTINAL</td>
<td>249</td>
<td>241</td>
<td>8</td>
<td>129</td>
<td>120</td>
</tr>
<tr>
<td>Esophagus</td>
<td>9</td>
<td>9</td>
<td>0</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Stomach</td>
<td>20</td>
<td>20</td>
<td>0</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Colon/Rectum</td>
<td>160</td>
<td>155</td>
<td>5</td>
<td>74</td>
<td>86</td>
</tr>
<tr>
<td>Anal</td>
<td>14</td>
<td>13</td>
<td>1</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Pancreas</td>
<td>25</td>
<td>23</td>
<td>2</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Other GI</td>
<td>21</td>
<td>21</td>
<td>0</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>GYNECOLOGIC</td>
<td>209</td>
<td>194</td>
<td>15</td>
<td>0</td>
<td>209</td>
</tr>
<tr>
<td>Cervix Uteri</td>
<td>68</td>
<td>66</td>
<td>2</td>
<td>0</td>
<td>68</td>
</tr>
<tr>
<td>Corpus Uteri</td>
<td>67</td>
<td>65</td>
<td>2</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td>Ovary</td>
<td>44</td>
<td>36</td>
<td>8</td>
<td>0</td>
<td>44</td>
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<tr>
<td>Other Gyn</td>
<td>30</td>
<td>27</td>
<td>3</td>
<td>0</td>
<td>30</td>
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<tr>
<td>HEAD AND NECK</td>
<td>190</td>
<td>183</td>
<td>7</td>
<td>91</td>
<td>99</td>
</tr>
<tr>
<td>Oral Cavity</td>
<td>21</td>
<td>21</td>
<td>0</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Pharynx</td>
<td>32</td>
<td>31</td>
<td>1</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>Salivary Gland</td>
<td>16</td>
<td>14</td>
<td>2</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Larynx</td>
<td>25</td>
<td>24</td>
<td>1</td>
<td>24</td>
<td>1</td>
</tr>
<tr>
<td>Thyroid</td>
<td>85</td>
<td>82</td>
<td>3</td>
<td>19</td>
<td>66</td>
</tr>
<tr>
<td>Other Head &amp; Neck</td>
<td>11</td>
<td>11</td>
<td>0</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>LUNG</td>
<td>88</td>
<td>181</td>
<td>7</td>
<td>82</td>
<td>106</td>
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<tr>
<td>LYMPH NODES</td>
<td>43</td>
<td>38</td>
<td>5</td>
<td>18</td>
<td>25</td>
</tr>
<tr>
<td>BONE MARROW</td>
<td>53</td>
<td>47</td>
<td>6</td>
<td>27</td>
<td>26</td>
</tr>
<tr>
<td>SKIN*</td>
<td>50</td>
<td>42</td>
<td>8</td>
<td>29</td>
<td>21</td>
</tr>
<tr>
<td>SOFT TISSUE SARCOMA</td>
<td>12</td>
<td>12</td>
<td>0</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>CNS</td>
<td>16</td>
<td>14</td>
<td>2</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>OTHER</td>
<td>11</td>
<td>8</td>
<td>3</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>UNKNOWN PRIMARY</td>
<td>23</td>
<td>23</td>
<td>0</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>ALL SITES TOTAL</td>
<td>1,944</td>
<td>1,845</td>
<td>99</td>
<td>713</td>
<td>1,231</td>
</tr>
</tbody>
</table>

*Skin – Excludes basal/squamous skin cancers
Source: GBMC Cancer Registry Database
staging system, T relates to extent of the primary tumor, N relates to lymph node involvement and M indicates the presence of distant metastases. The combination of the TNM provides a stage group classification of Stage 0, 1, 2, 3, 4, or unstageable. Cancers may be unstageable because no AJCC staging classification exists for the site. For example, leukemias, unknown primaries, and primary brain tumors cannot be staged using the AJCC criteria. Also, patients may be unstageable because they choose to forego treatment or further testing needed to determine the appropriate stage. At diagnosis, 12.2% of GBMC’s 1,845 analytic cases were Stage 0 (in situ), the earliest stage tumors. In general, the survival rates for in-situ cancers are higher than for those of invasive cancers. Of the invasive cancers, 29.0% were Stage 1; 25.1% were Stage 2; 12.1% were Stage 3; 12.2% were Stage 4; and 9.4% had no AJCC stage for the site or were unstageable (Table 3).

### Table 2
**GBMC Site Distribution by Sex 2006**
*Based on 1,845 Analytic Cases*

<table>
<thead>
<tr>
<th></th>
<th><strong>MALES</strong></th>
<th>671 (36%)</th>
<th><strong>FEMALES</strong></th>
<th>1,174 (64%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melanoma</td>
<td></td>
<td>19 (2.8)</td>
<td>Melanoma</td>
<td>15 (1.3)</td>
</tr>
<tr>
<td>Oral</td>
<td></td>
<td>30 (4.5)</td>
<td>Oral</td>
<td>16 (1.4)</td>
</tr>
<tr>
<td>Lung</td>
<td>78 (11.6)</td>
<td></td>
<td>Breast</td>
<td>505 (43.0)</td>
</tr>
<tr>
<td>Pancreas</td>
<td>11 (1.6)</td>
<td></td>
<td>Lung</td>
<td>98 (8.3)</td>
</tr>
<tr>
<td>Stomach</td>
<td>9 (1.3)</td>
<td></td>
<td>Pancreas</td>
<td>11 (0.9)</td>
</tr>
<tr>
<td>Colon/Rectum</td>
<td>72 (10.7)</td>
<td></td>
<td>Colon/Rectum</td>
<td>82 (7.0)</td>
</tr>
<tr>
<td>Urinary</td>
<td>61 (9.1)</td>
<td></td>
<td>Ovary</td>
<td>32 (2.7)</td>
</tr>
<tr>
<td>Prostate</td>
<td>205 (30.6)</td>
<td></td>
<td>Uterus</td>
<td>118 (10.1)</td>
</tr>
<tr>
<td>Leukemia &amp; Lymphoma</td>
<td>36 (5.4)</td>
<td></td>
<td>Leukemia &amp; Lymphoma</td>
<td>41 (3.5)</td>
</tr>
<tr>
<td>All Other</td>
<td>150 (22.4)</td>
<td></td>
<td>All Other</td>
<td>224 (19.1)</td>
</tr>
</tbody>
</table>

© 1997, Onco, Inc. - Numbers based on ACS All Sites distribution  
Source: GBMC Cancer Registry
The cervix is that portion of the uterus sometimes referred to as the “birth canal” and extends into the upper portion of the vagina. This enables access to the screening study known as the “Pap test” which has resulted in the sharp decline of invasive cancers since pre-malignant and non-invasive lesions are now detected and treated much more frequently. Success in treating cervical cancer at GBMC reflects the sophistication of gynecologic oncology services, which far exceeds the capabilities of other community hospitals in the Baltimore area.

Approximately 9,700 new cases of cervical cancer were diagnosed in 2006 in the United States, while in Maryland there were estimated to be 210 women diagnosed that year. Because of screening and early detection, the disease is often detected before symptoms develop. The most common symptom is abnormal vaginal bleeding during or between menstrual periods or after sexual intercourse. Women can also present with vaginal discharge or postmenopausal bleeding.

The most common cause of cervical cancer is an infection by the human papilloma virus (HPV), a risk which is greatest in women who have multiple sexual partners or begin sexual activity at a young age. Persistence of the HPV infection and progression to cancer can be influenced by suppression of the immune system, cigarette smoking and other factors. Of great importance is the recent availability of two vaccines which, by preventing infection from the most common strains of the HPV virus, can prevent the development of cervical cancer.

There are several treatment options available to women with pre-invasive cervical lesions. These include electrocoagulation, cryotherapy, laser resection and limited surgery. For early stage invasive cancers, a wider surgical removal or radiotherapy is considered. For women who present with more advanced cancers, recent studies have indicated that outcomes can be improved by adding chemotherapy to radiotherapy.

The survival for women with pre-invasive cervical cancer approaches 100 percent. Even when detected at an early stage of invasion, the five-year cure rate exceeds 90 percent. As with most cancers, the success rates decline sharply with more advanced cancers highlighting the importance of prevention and early detection. There were 3,700 estimated deaths in 2006 from cervical cancer nationwide.

Table I demonstrates the age at diagnosis of cervical cancer in the year 2006 for our patient population. Table II reflects the histologic distribution of cervical cancer at GBMC between 1995-2002. The striking difference in our proportion of patients with intraepithelial neoplasia reflects the high rate of patients undergoing PAP studies who have cancers identified by routine screening.

Table III, in similar fashion, shows the large proportion of pre-invasive and early stage disease seen at our institution.
Table I
Cervical Cancer
Age at Diagnosis 2005

Table II
Cervical Cancer
Histology

### Table II
Cervical Cancer
Histology

<table>
<thead>
<tr>
<th>HISTOLOGY</th>
<th>GBMC N=(554)</th>
<th>NCDB N=15,408</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carcinoma, NOS</td>
<td>0.20%</td>
<td>7.00%</td>
</tr>
<tr>
<td>Squamous Cell Carcinoma, NOS</td>
<td>12.60%</td>
<td>41.40%</td>
</tr>
<tr>
<td>Keratinizing Squamous Cell Carcinoma, NOS</td>
<td>1.00%</td>
<td>4.20%</td>
</tr>
<tr>
<td>Large Cell, Nonkeratinizing Squamous Cell Carcinoma</td>
<td>0.10%</td>
<td>4.10%</td>
</tr>
<tr>
<td>Microinvasive Squamous Cell Carcinoma</td>
<td>1.80%</td>
<td>1.70%</td>
</tr>
<tr>
<td>Intraepithelial Neoplasia, Grade III (CIN 3)</td>
<td>67.30%</td>
<td>20.70%</td>
</tr>
<tr>
<td>Adenocarcinoma, NOS</td>
<td>4.00%</td>
<td>10.80%</td>
</tr>
<tr>
<td>Adenosquamous Carcinoma</td>
<td>2.00%</td>
<td>2.30%</td>
</tr>
<tr>
<td>Other Specified Types</td>
<td>11.00%</td>
<td>7.70%</td>
</tr>
</tbody>
</table>
Table IV outlines the five-year survival of patients treated at GBMC compared with the National Cancer Data Base. There was a superior survival for GBMC patients in all but Stage II. An analysis of Stage II patients revealed why: too few patients for statistical validity and a disproportionate number having co-morbidities such as advanced age (in 80s and 90s), or poor performance status limiting the ability to deliver curative therapies. A greater number of NCDB patients with Stage II disease could undergo surgery, suggesting a greater percentage of patients with Stage IIA vs. IIB disease, an important difference. Finally, fewer patients in the earlier years were receiving combined chemo-radiotherapy (see Table V), which is now a standard of care.

The treatment of cervical cancer has evolved over the years, and the prognosis has never been better. Development of vaccines can prevent the disease altogether, while screening leads to early detection when the disease is almost always curable. With Francis Grumbine, MD, Chairman of the Department of Gynecology and Michael Dillon, MD, we are fortunate to have two outstanding gynecologic oncologists on our staff. Paul Celano, MD, is Chief of the Division of Medical Oncology in the Department of Medicine, and has a special interest in gynecologic malignancies. The special expertise of these individuals, along with a very caring staff, assures the highest quality of care for our patients. Newer technologies at GBMC now permit many of our cases to be treated as outpatients. Even for the most advanced cancers, the combination of chemotherapy with radiotherapy has improved survival. And, overall, our survival rates have been superior to those seen in the National Cancer Data Base.

Table III
Cervical Cancer
Comparison of AJCC Staging

<table>
<thead>
<tr>
<th>Stage 0</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>84.8%</td>
<td>76.4%</td>
<td>38.0%</td>
<td>15.0%</td>
<td>25.8%</td>
<td>12.6%</td>
</tr>
<tr>
<td>10.0%</td>
<td>7.6%</td>
<td>3.0%</td>
<td>2.5%</td>
<td>3.0%</td>
<td>11.7%</td>
</tr>
<tr>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
<td>4.0%</td>
<td>1.5%</td>
<td>5.9%</td>
</tr>
<tr>
<td>0.0%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>6.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
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</table>
Table IV
5 Year Survival
Cervical Cancer at GBMC
1995–2002

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 0</td>
<td>N = 392 96.70%</td>
<td>N = 40,950 91.00%</td>
</tr>
<tr>
<td>Stage 1</td>
<td>N = 82 92%</td>
<td>N = 12,436 82.3%</td>
</tr>
<tr>
<td>Stage 2</td>
<td>N = 142 8.6%</td>
<td>N = 4,182 51.75%</td>
</tr>
<tr>
<td>Stage 3</td>
<td>N = 22 44.6%</td>
<td>N = 4,126 36.1%</td>
</tr>
<tr>
<td>Stage 4</td>
<td>N = 11 18.2%</td>
<td>N = 2,054 11.3%</td>
</tr>
</tbody>
</table>

Source: NCDB, Commission on Cancer; ACoS/ACS Survival Report v2.0

Table V
Cervical Cancer
Comparison of AJCC Staging

<table>
<thead>
<tr>
<th>Treatment</th>
<th>GBMC N=14</th>
<th>NCDB Benchmark N=1,934</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery Alone</td>
<td>7.1</td>
<td>12.3</td>
</tr>
<tr>
<td>Radiation only</td>
<td>10.9</td>
<td>57.1</td>
</tr>
<tr>
<td>Chemo only</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Surgery/Rad</td>
<td>0.0</td>
<td>8.6</td>
</tr>
<tr>
<td>Surgery/Chemo</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Radiation/Chemo</td>
<td>28.6</td>
<td>47.3</td>
</tr>
<tr>
<td>Surg/Rad/Chemo</td>
<td>0.0</td>
<td>14.9</td>
</tr>
<tr>
<td>Other comb</td>
<td>0.0</td>
<td>2.2</td>
</tr>
<tr>
<td>No tx</td>
<td>3.8</td>
<td>7.1</td>
</tr>
</tbody>
</table>
"US TOO" INTERNATIONAL PROSTATE CANCER EDUCATION AND SUPPORT NETWORK
GBMC’s free support group was the first prostate cancer support group in the area. Partners and family members are welcome. The first hour is devoted to educational topics and the second hour to participants sharing personal experiences. Facilitator: Michele Better, LCSW-C. For more information call 443-849-2961.

LOOK GOOD, FEEL BETTER®
This free program is held at GBMC in conjunction with the American Cancer Society. The focus is to help women undergoing cancer treatments to regain a sense of self-confidence and to cope with appearance-related side effects of treatment, including hair loss and changes in complexion and fingernails. Facilitator: Laura Chase, Community Outreach Specialist. For more information call 443-849-2037.

BRIZEL DISCUSSION GROUP
Started in 2005, this free group was organized for patients and their families who have undergone a specific treatment for head and neck cancer known as the Brizel Protocol. Newly diagnosed and long-time survivors of head and neck cancer have an opportunity to share treatment experiences, struggles and successes with other patients, family members, friends and professionals. This group meets quarterly. Facilitators: Barbara P. Messing, MA, CCC-SLP, BRS-S and Dorothy Gold, LCSW-C. For more information call 443-849-2087.

LARYNGECTOMEE INTEREST GROUP
GBMC’s Dance Center offers a free support group that provides news and information relevant to people who have had a laryngectomy. Participants also have the opportunity to share their experiences and practice voicing. Facilitators: Barbara P. Messing, MA, CCC-SLP, BRS-S, Melissa Walker, MS, CCC-SLP and Dorothy Gold, LCSW-C. For more information call 443-849-2087.

PATIENT/FAMILY HEAD AND NECK CENTER SUPPORT GROUP
GBMC’s free support group is composed of newly diagnosed and long-time survivors of head and neck cancer. Family members or significant others are also encouraged to attend meetings. Facilitators: Dorothy Gold, LCSW-C and Karen Ulmer, RN, MS, CORLN. For more information call 443-849-2087.