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2010-2011

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Pathology

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Radiology / Interventional Radiology

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Mark Seligman, MD
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Scott Smith, MD
Hospice

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Cancer Program Coordinator

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Specialty Rehabilitation / Occupational Therapy

Dulcie Ward, RD
Nutritional Services
Chair’s Report
by M.C. Theodore Mackett, MD

The Cancer Program Report is an annual review of the cancer program at Adventist Medical Center. I have had the privilege to chair the Cancer Committee for the past two years and to have had the opportunity to observe at close range the tremendous scope of activities embodied in the care of malignant disease at our hospital. I invite your careful consideration of the contents of this report which speak directly to the many facets of the cancer program.

The cancer program is more than ever a multidiscipline team effort at Adventist Medical Center. The patient is the focus of all our endeavors. The team is comprised of surgical, medical, and radiation oncologists, radiologists, pathologists, oncology nurse specialists, physical therapists, occupational therapists, hospice physicians and nurses, the chaplains, and many support personnel both in the medical center and in the clinical offices: social and psychological support services, home health nurses, technicians, treatment coordinators, rehabilitation services, speech therapists, nutritional services, and pharmacy. The entire team meets on a quarterly basis to review the cancer treatment activities, to learn ways in which the program can be improved, and to provide opportunity to advance the objectives of our joint efforts.

The twice monthly Cancer Conference is where new patients with recent diagnoses of cancer are first introduced to the “team”, where treatment recommendations are made in accordance with the NCCN guidelines, where that treatment is reviewed in timely follow up, and where advances can be shared in a learning environment that ultimately benefits the patients. Dr. Rebecca Orwoll, medical oncologist, has led out in the Cancer Conferences. Attendance has been excellent because of the enhanced content and interest of the conferences. Continuing medical education (CME) credit has again been approved by the medical center education committee in accordance with established requirements. The annual oncology lecture for the medical staff featured Roger Rosenquist, MD in a discussion of Bladder Cancer.

The Cancer Data Services/Cancer Registry is at the heart of the cancer program. Laura Wallace, RHIT, CTR, Cancer Program Coordinator, has provided outstanding service this past year collecting accurate and comprehensive patient data, meeting the standards and accreditation of the American College of Surgeons and the standards of the Oregon State Cancer Registry. She was instrumental in the three year reaccreditation of the Cancer Program by the American College of Surgeons. Maintaining the affiliation of the Cancer Registry with the state and national organizations allows statistical analysis of cancer incidence and distribution throughout the region and nationally. A total of 398 cases were accessioned in 2010.

Progress has been realized in the recent past, and U.S. mortality rates for 14 of the 19 most deadly cancers have declined from 2003 to 2007, according to the National Cancer Institute. Better screening tests for colorectal, prostate, and breast cancer have led to early detection and contributed to better survival rates. Lung cancer in both men and women is declining. About a third of U.S. cancer deaths are still linked to tobacco, although the number of smokers in the country is down because of public education, higher taxes on tobacco products, public smoking restrictions and awareness campaigns, and warning labels mandated by law. Cancers without reliable screening tests—such as pancreatic, liver, and uterine—or effective treatments, however, still have rising death rates. The five-year survival rate for pancreatic cancer patients is 6 percent, compared to over 90 percent for some forms of breast and prostate cancer.

Looking ahead to the future, growing and aging populations will make cancer more common. Changes that come with economic growth, such as diet and less physical activity, will also play a role. The cancer program at Adventist Medical Center will, undoubtedly continue to serve the local community and beyond with both preventive and therapeutic endeavors in the continued war on cancer.

M.C. Theodore Mackett, MD
Chairman, Adventist Medical Center’s Cancer Committee
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Acknowledgements

Special thanks to:

Rebecca Orwoll, M.D.
M.C. Theodore Mackett, MD
Lynne Dawson, MD

From the Cancer Data Services Staff:
Laura Wallace, RHIT, CTR
Sally Bulahao

Our Mission . . . to demonstrate the human expression of the healing ministry of Jesus Christ.
We commit to:
  • Delivering whole-person care that nurtures body, mind, and spirit;
  • Encouraging living well by promoting a healthy lifestyle;
  • Reflecting God’s love by serving with compassion, dignity and respect;
  • Improving the health of the communities we serve;
  • Providing services in the most medically and financially appropriate setting;
  • Delivering compassionate, high quality care with technical excellence;
  • Creating a safe environment of care that inspires trust and confidence;
  • Serving as a faith-based health care organization consistent with the philosophy of the Seventh-day Adventist church.

Our Vision
We will be the market leader in delivering innovative, accessible, cost-effective, high quality, whole-person care. We will be recognized for exceptional service consistently demonstrating our mission and values.

Our Values
In partnership with God, we will fulfill our mission and vision by treating others in harmony with our values:

Integrity – Ensure our actions are consistent with our values
Quality – Provide care that is safe, reliable and patient-centered
Compassion – Reflect the love of Jesus through care, respect and empathy
Wholeness – Embrace a balanced life – integrating mind, body and spirit
Respect – Recognize the God-given dignity and individuality of each person
Family – Support each other in achieving our shared purpose
Stewardship – Serve our community through responsible resource management

www.AdventistHealthNW.com
There have been significant advances in outcome for colorectal cancer in the last few years, most especially in screening and in systemic treatment. Colon cancer is the fourth most commonly diagnosed cancer in the US, and the second leading cause of cancer death. There will be about 140,000 new cases in the US recorded in 2011. On the other hand, the incidence has decreased from 60.5 per 100,000 in 1976 to 46.4 in 2005, and mortality has decreased by about 35% from 1990 to 2007.

Since about 20% of cases of colon cancer are associated with family clustering, whether with a syndrome such as Lynch non-polyposis, or familial polyposis, or with a less well defined family risk, both genetic testing for appropriate families, and more aggressive screening are warranted. Also patients with inflammatory bowel disease have increased risk. Current recommendations support high-sensitivity fecal occult blood testing yearly, sigmoidoscopy every five years, or colonoscopy every ten years, starting at age 50 for everyone, but earlier depending on family history. There is controversy about detection of right sided lesions using only sigmoidoscopy, as well as about the sensitivity of fecal testing. As well, thorough preparation affects the reliability of endoscopy. The US Preventive Services Task Force does not currently endorse virtual colonoscopy nor air-contrast barium enema as standard. Though the recommended tests are not 100% sensitive, the USPSTF estimates nearly 19,000 lives per year would be saved by screening the entire population.

Other factors associated with increased risk include excessive alcohol use, cigarette smoking, and obesity, according to the National Cancer Institute. Increased physical activity is associated with decreased risk. There is evidence that some interventions decrease risk, including nonsteroidal anti-inflammatory medications, aspirin, postmenopausal hormone use, diet modifications, calcium and perhaps vitamin D supplementation, and statins. A diet low in fat and meat, and high in fiber, fruits, and vegetables, is associated with decreased risk, with fair supportive evidence. Polyp removal is associated with decreased risk, especially for larger polyps.

Although it is the goal that invasive colorectal cancer be prevented, in the past ten years or so there have been significant advances in systemic therapy given in the adjuvant setting as well as given as therapy for metastatic disease. For perspective, until the mid 1990’s only 5-fluorouracil (5FU) was approved for colorectal cancer.

Apart from a clinical trial, stage I patients are generally not offered adjuvant therapy. Low-risk stage II patients might be enrolled on a clinical trial, might be offered only observation, or might be offered leucovorin-modulated 5FU. In addition, Oncotype, a genetic risk assessment now frequently used to help in treatment decisions for breast cancer, is commercially available for patients with colon cancer. Genetic testing of the tumor itself is anticipated to provide meaningful information to guide adjuvant treatment of clinically lower-risk patients. Higher risk stage II, and all stage III patients, per the guidelines of the National Comprehensive Cancer Network (NCCN), are offered adjuvant systemic chemotherapy. Standard treatment options are all based on 5FU and leucovorin, generally with oxaliplatin as well. At this time adjuvant therapy does not generally include bevacizumab, cetuximab, panitumumab, or irinotecan outside the setting of a clinical trial. An interesting observation attributed to adjuvant treatment, is that relapses are delayed due to the effect of therapy. Thus more than six years is needed to assess the benefit of such therapies. On the other hand, the relapse rate is extremely low after eight years, suggesting that patients who remain disease free longer than eight years may likely be cured. It should also be noted that the absolute benefit of adjuvant therapy is modest, which makes the point that prediction of high risk tumors at a genetic level will be very helpful in the future, better to define patients who may safely avoid treatment.

Radiation is added in patients whose colon tumors have penetrated a fixed structure, and is generally used in patients with rectal tumors.

There have been a variety of types of advances in the treatment of metastatic disease. Hepatic lesions may be resected in select patients, and a small number may become resectable after chemotherapy. True cure, while still not the norm, can occur in this patient population, and 5 year survival is approximately 20%. Less strong data support infusional therapy into liver metastases. Selected symptomatic lesions are treated with radiation therapy. Most patients are best treated with systemic chemotherapy, with additional benefit for some from targeted therapy. Although none of these patients ought to anticipate cure of disease, survival for several years is no longer unusual. Each individual advance has been shown to add months to a survival curve, leading to a meaningful cumulative benefit for some patients. The NCCN guidelines, and other sources, provide many options which can be tailored to the goals of therapy, comorbid conditions of the patients, and side effects experienced.
The data from Adventist Medical Center are based on 61 cases from 2003, and 41 cases from 2008. The sample size has decreased, consistent with the nationwide decrease in incidence.

**Five-year Observed Survival Rates: Colorectal**

**Stage I**

<table>
<thead>
<tr>
<th>Year</th>
<th>AMC (8 cases)</th>
<th>NCDB (1,845 cases)</th>
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<tr>
<td>5 yr</td>
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**Stage II**

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<tr>
<td>5 yr</td>
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**Stage III**

<table>
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<th>NCDB (2,070 cases)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>3 yr</td>
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<tr>
<td>4 yr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 yr</td>
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</tbody>
</table>
Stage IV

Overall
Colorectal cancer continues to be a major health concern both in the United States and in the world. Approximately 150,000 new cases of colorectal cancer are reported annually in this country, with about 50,000 deaths. The World Health Organization estimates that 945,000 new cases occur worldwide every year, with 492,000 deaths. Colorectal cancer is more common in the developed than developing countries. In the developed countries it is the second most common tumor, with a lifetime incidence of 5%. Outcome is proportional to access to care; the overall 5 year survival exceeds 60% in the United States, but is less than 40% in less developed countries (1). The overall mortality has continued to fall steadily over recent years in this country. Colorectal cancer screening, improved surgical techniques, better imaging, high quality pathology, and neoadjuvant/adjuvant therapy have contributed to this encouraging trend.

Most cases of colorectal cancer are sporadic. However, risk factors for developing colorectal cancer include a personal or family history of colorectal cancer or polyps. About 20% of all patients with this cancer are estimated to have some component of familial risk. Family history is important when assessing the patient with colorectal cancer even though family history by interview often underestimates family history of colorectal cancer (2, 3).

Approximately 5-10% of all colorectal cancers develop in patients with a hereditary cancer syndrome. The two common forms are hereditary nonpolyposis colorectal cancer (HNPCC) and familial adenomatous polyposis (FAP). Other hamartomatous polyposis syndromes are also associated with an increased risk such as Peutz-Jeghers syndrome, juvenile polyposis syndrome, and Cowden syndrome (4). Inflammatory bowel disease predisposes to the development of colorectal cancers. Both chronic ulcerative colitis and Crohn’s colitis are associated with a significantly increased risk of colorectal cancer (5).

Screening for colorectal cancer is effective in reducing mortality from this disease in patients at high risk but also in the general population. A very recent study widely reported in the public press showed a significant decrease in mortality in patients who had screening colonoscopy (6). Another study reported in the same journal issue showed fecal immunochemical testing detected colorectal cancer almost as frequently as did colonoscopy, but more adenomas were identified in the colonoscopy group (7). Patient compliance is an on-going challenge in screening. In the colonoscopy study, patient compliance was less satisfactory than in the fecal immunochemical testing group. Other screening examinations that have been available include flexible sigmoidoscopy, double contrast barium enema, and virtual colonoscopy. Colonoscopy remains the “gold standard”, however, in spite of higher cost, patient risk, and patient inconvenience. Development of a screening blood test to assess the personal risk for colorectal cancer is still not available, although several biomarkers are under investigation.

Prevention of colorectal cancer can be realized with lifestyle change. Tobacco avoidance, physical activity, weight control, and dietary interventions have been associated with decreased risk. Chemoprevention is under investigation. Aspirin and nonsteroidal anti-inflammatory drugs have shown significant risk reduction. Surgery also plays a role in risk reduction and prevention. Restorative proctocolectomy with ileoanal J-pouch is the recommended procedure for familial adenomatous polyposis (FAP) and ulcerative colitis. Prophylactic colectomy has also been suggested by some for the treatment of carefully selected patients with hereditary non-polyposis colon cancer (Lynch syndrome) (8).

Understanding of colorectal carcinogenesis at the molecular level with recognized mutations or epigenetic changes of genes has contributed to the development of more effective chemotherapeutic agents and protocols, and the recognition of tumor related prognostic factors in the treatment of colorectal cancers. The role of chemotherapy and indication for radiation therapy in the treatment of colorectal cancer are discussed by colleagues elsewhere.

Surgical advances of recent years include the increasing utilization of laparoscopic and hand-assisted laparoscopic colorectal resection, which have decreased the length of hospital stay, recognition that the number of removed lymph nodes directly impacts the staging and, therefore, the prognosis of colorectal cancers (9). Mapping of sentinel lymph nodes has not proven of practical or prognostic value to date. Resection margins are among the most important prognostic factors as well (10). Total mesorectal excision for surgery of rectal cancer has been one of the most important recent advances. Local recurrences and perioperative morbidity have been reduced (11). Laparoscopically assisted resection and robot assisted pelvic procedures have been employed in these advances. Long-held traditions have fallen by the way.
Routine use of nasogastric tubes, preoperative bowel preparation, postoperative fasting, and intraoperative fluid excess have been safely omitted. So called “fast track” surgery has resulted in reduced hospital stay, perioperative morbidity, and cost.

What does the future portend? With elucidation of the molecular genesis of colorectal cancer, targeted therapies focusing on specific tumor profiles might become possible. Prediction of individual risk, screening, and prevention might become a reality. Public education is key to achieving better outcomes. Surgical quality control is paramount and can be achieved with better education of the physicians who care for patients. The team approach grounded on evidence-based medicine will allow further advances in the management of this common disease.

There is currently no standard role for adjuvant radiation therapy in the management of patients with surgically resected colon cancer (cancer above the peritoneal reflection). While patterns of care studies and single institution retrospective reviews have suggested a role for radiation therapy in high risk subsets such as T4 lesions, location in immobile sites, local perforation and residual disease post resection, a phase III randomized intergroup study to address this question failed to accrue adequate numbers and closed early. Analysis of 222 of a planned 700 patients showed no clear overall survival or local control benefit in patients receiving radiation therapy (XRT), yet sample size and statistical power were inadequate to exclude benefit (Martenson, JA, 2004). Adjuvant XRT may be considered in surgically resected patients with residual disease who are node negative but have close/positive margins and a well-defined tumor bed.

Combined modality therapy with chemotherapy and XRT plays a significant role in the management of patients with rectal cancer (cancer straddling or below the peritoneal reflection). The Gastrointestinal Study Group showed in a randomized trial (227 patients with stage B2-C rectal cancer randomized to postoperative observation vs. chemo alone vs. XRT alone vs. concurrent chemoradiation) improved 5 year disease free survival in patients treated with chemoradiation (Thomas, PR, 1988). This became the basis for the NIH Consensus Conference recommendation for postoperative chemoradiation (NIH, 1990).

The results of The German Rectal Cancer Study Group’s prospectively randomized trial involving 823 patients comparing preoperative versus postoperative chemoradiation for T3/4 or N+ rectal cancer were practice changing. Preoperative chemoradiation improved the 5 year local recurrence rate (6% vs. 13%), increased the rate of sphincter saving procedures (39% vs. 19%) and decreased acute and late toxicity. Positive lymph nodes were noted in 25% of the preoperative group vs. 40% in the postoperative group and pathologic complete remission occurred in 8% of the preoperative group. There was no significant difference in 5 year overall survival between the groups (76% vs. 74%). Neoadjuvant therapy using chemoradiation is thus now preferred to postoperative therapy for patients with stage II and III disease. With preoperative chemoradiation, there is opportunity for tumor regression and downstaging, improved resectability, and a higher rate of sphincter preservation and local control (Sauer, R, 2004).

Radiation therapy may be indicated in various settings involving rectal cancer (Nash, MB, 2010):

**Stage I:** If a T2 lesion has been treated by local excision alone then chemoradiation is indicated.

**Stage II and III:** Preop chemoradiation (preferred, see paragraph #3 above) followed by total mesorectal excision (TME) with low anterior resection/abdominal perineal resection, followed by adjuvant chemotherapy. If surgery pursued first, then follow with chemoradiation.

**Stage III** (T4/ locally unresectable): May need diverting colostomy first if obstructed. Chemoradiation, then resect if possible. Consider XRT boost for residual disease (Intensity Modulated Radiation Therapy -IMRT vs. intraop vs. brachytx)

**Stage IV:** Individualized options. May involve XRT.

**Recurrent:** Individualized options. Consider chemoradiation if no prior XRT, then resect if possible. If prior XRT, then chemotherapy followed by surgery +/- XRT (IMRT, intraop or brachytx).

**Radiation Treatment / Toxicity**

Radiation therapy for rectal cancer typically utilizes a prone position with multiple pelvic fields designed to treat the primary tumor with margin, presacral and internal iliac nodes plus external iliac nodes if T4 lesion.

High energy radiation is utilized and fields are custom contoured through the use of 3 dimensional or other advanced radiation planning techniques. Bladder distention and customized patient molds are used to exclude as much small bowel as possible from the treatment fields.
Radiation dose range is typically 4500-5040 cGy (180cGy X 25-28 fx) along with concurrent chemotherapy (5-FU based). A boost to 5400cGy-5940 cGy total may be considered if surgical resection is not planned and small bowel can be excluded from treatment fields.

Potential side effects include fatigue, minor skin changes, diarrhea, dysuria and lowered blood counts. Gastrointestinal side effects are usually self limiting and typically resolve in 4 to 6 weeks with fatigue improving over 6-8 weeks post treatment completion. Late morbidity may include change in bowel habits, rectal urgency, diarrhea or more rarely anastomotic stricture or small bowel obstruction.

Survival

The 1 and 5 year national survival rates for patients with colorectal cancer are 83% and 65%, with 10 year survival of 58%. Colorectal cancer diagnosed at an early localized stage has a 5 year survival of 90%. In contrast, when colorectal cancer involves adjacent organs or lymph nodes, 5 year survival is 70%. With distant metastases, the 5 year survival is 12% (Cancer Facts & Figures 2011).

At Adventist Medical Center, the 1 year survival for all cases diagnosed in 2003 was 78% and 5 year survival was 58%. The 5 year survival for patients with early localized disease was 76%, and the 5 year survival for patients with adjacent organ or nodal involvement was 76%. The 5 year survival for patients with Stage IV disease was 12%. Small patient numbers in each stage are likely contributing to the differences in survival outcomes, making comparison with national data difficult.

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**Incidence Rates** for Oregon, 2004 - 2008

**Colon & Rectum**

All Races (includes Hispanic), Both Sexes, All Ages

*Created by statecancerprofiles.cancer.gov on 09/27/2011 2:10 pm.*

**State Cancer Registries** may provide more current or more local data. Data presented on the State Cancer Profiles Web Site may differ from statistics reported by the State Cancer Registries (for more information).

Incidence rates (cases per 100,000 population per year) are age-adjusted to the 2000 US standard population (19 age groups <1, 1-4, 5-9, .., 80-84, 85+). Rates are for invasive cancer only (except for bladder which is invasive and in situ) or unless otherwise specified. Rates calculated using SEER*Stat. Population counts for denominators are based on Census populations as modified by NCI. The US populations included with the data release have been adjusted for the population shifts due to hurricanes Katrina and Rita for 22 counties and parishes in Alabama, Mississippi, Louisiana, and Texas. The 1999-2008 US Population Data File is used with SEER November 2010 data. The 1999-2008 US Population Data File is used with NPCR January 2011 data.

** Data have been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 10 cases were reported in a specific area or race category.

** Data have been suppressed for states with a population below 50,000 per sex for American Indian/Alaska Native or Asian/Pacific Islanders because of concerns regarding the relatively small size of these populations in some states.

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**Age-Adjusted Annual Incidence Rate**

(Cases per 100,000)

<table>
<thead>
<tr>
<th>Quartile Interval</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.2 to 34.6</td>
<td>47.8</td>
</tr>
<tr>
<td>41.9 to 45.0</td>
<td>43.9</td>
</tr>
<tr>
<td>34.0 to 39.3</td>
<td>43.0</td>
</tr>
<tr>
<td>Suppressed ***</td>
<td></td>
</tr>
</tbody>
</table>

US (SEER + NPCR) Rate (95% C.I.)

47.6 (47.5 - 47.7)

Oregon Rate (95% C.I.)

43.9 (43.0 - 44.8)
Age-Specific (Crude) U.S. Mortality Rates
By Cancer Site
All Ages, All Races, Both Sexes
2000-2008

Cancer sites include invasive cases only unless otherwise noted.
Mortality source: US Mortality Files, National Center for Health Statistics, CDC.
Rates are per 100,000.
Datapoints were not shown for rates that were based on less than 16 cases.
Cancer Facts & Figures. 2011


Adventist Medical Center (AMC) has been an Accredited Cancer Program overseen by the American College of Surgeons, Commission on Cancer since 1985. The Cancer Registry database is an essential component of our cancer program and functions in accordance with guidelines set by the American College of Surgeons (ACoS). AMC is re-surveyed every three years to assure continuous compliance with the accreditation standards.

Under the direction of the Cancer Program, the registry coordinated by Laura Wallace, RHIT, CTR, contains an oncology database that integrates a complete summary of patient history, diagnosis, stage of disease, treatment, and status of every patient diagnosed and/or treated at AMC. Data is entered in the database following defined standards set by the Commission on Cancer.

The Cancer Registry is involved in managing and analyzing clinical cancer data to collaborate with physicians, administrators, and health care planners to provide support for cancer program development, treatment, provide cancer incidence, and to ensure compliance of reporting standards. The registry also serves as an essential resource for cancer information with the objectives of improving outcomes of cancer therapy as well as improving the quality of life of cancer patients through quality improvement, outcome measurements, outreach, and research activities. The registry database contains over 11,000 patients that have come to AMC for diagnosis and/or treatment of cancer since 1985.

In 2010, 467 cases were accessioned, 398 of these were new analytic cases (required by law) reported to the state and national cancer databases; 69 were non-analytic. Of the 398 analytic cases, 223 were female and 175 were male. The major sites were: 95 breast (24%) cases; 69 lung cases (17%); 39 colorectal cases (10%); 37 prostate cases (9%); and 30 bladder (7.5%).

The Cancer Registry has had many accomplishments for the year 2010. Below are some highlights of the many activities and achievements:

- 2011 Annual Cancer Report: compiled and published to provide in depth information on AMC’s Cancer Program with statistics for the prior year.
- Coordination of 22 cancer conferences with over 70 patient cases presented for multidisciplinary discussion, which

### 2010 AMC Primary Site Major Groups

<table>
<thead>
<tr>
<th>Primary Site</th>
<th>Cases</th>
<th>% of Cases</th>
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</thead>
<tbody>
<tr>
<td>Breast</td>
<td>95</td>
<td>23.87</td>
</tr>
<tr>
<td>Lung</td>
<td>69</td>
<td>17.34</td>
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<tr>
<td>Colon/Rectum</td>
<td>39</td>
<td>9.80</td>
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<tr>
<td>Prostate</td>
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</tr>
<tr>
<td>Gallbladder</td>
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</tr>
<tr>
<td>Mesothelioma</td>
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</tr>
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<td>Renal Pelvis/Ureter</td>
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</tr>
<tr>
<td>Intrahepatic Bile Ducts</td>
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</tr>
<tr>
<td>Appendix - Carcinoid</td>
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<td>0.50</td>
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<tr>
<td>Soft Tissue Sarcoma</td>
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</tr>
<tr>
<td>Corpus Uteri-Leio/Stromal Sarcoma</td>
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<tr>
<td>Lip/Oral Cavity</td>
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</tr>
<tr>
<td>Larynx - Supraglottis</td>
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</tr>
<tr>
<td>Vulva</td>
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</tr>
<tr>
<td>Testis</td>
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</tr>
<tr>
<td>Other Sites</td>
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**TOTAL CASES** 398 100%
includes review of American Joint Committee on Cancer (AJCC) physician staging and National Comprehensive Cancer Network (NCCN) guidelines.

- 467 cases accessioned and entered into the oncology database. 398 newly diagnosed and/or treated patient analytic cases.
- Cancer registry staff performs systematic annual follow-up of our cancer patients. Follow-up is vital in evaluating treatment modalities and behavior of certain cancers. At 98%, AMC exceeds the 90% required follow-up rate required by the American College of Surgeons.
- The quality of cancer data is essential in monitoring cancer patient outcomes and for research. To continually ensure the quality of our data, numerous physician reviews were conducted during 2010. The cancer registry database also performs systematic data review through registry oncology software, data submission to the National Cancer Data Base (NCDB) and the Oregon State Cancer Registry (OSCaR).
- To ensure that cancer services, care, and patient outcomes are measured and improved for all of our patients, Cancer Program Practice Profile Reports (CP3R) data is utilized to perform studies to measure quality and outcomes.
- More than 10% of cases reviewed by a physician for quality of registry data, AJCC staging and compliance with the College of American Pathologists (CAP) protocols per Commission on Cancer Standards.
- Cancer Data Services was responsible for 75 data requests and data submissions in 2010, some of which included:
  - National Cancer Data Base (NCDB)
  - Oregon State Cancer Registry (OSCaR)
  - Statistical analysis provided to AMC Cancer Committee
  - Routinely provide data for quality management analysis
  - Physician requests and studies
  - Administrative/planning analysis
  - Publications
  - Requests for treatment and follow-up information from other cancer registries
  - AMC values and supports ongoing cancer-related education and training for registry staff by promoting registrar attendance to state and local educational conferences and attendance to the yearly National Cancer Registrars Association Conference.

Thank you to Marsha Beal, RHIT, CTR support of the registry and to Sally Bulahao, registry assistant, in her efforts to coordinate AMC’s Cancer Conference and follow-up during 2010.

Breast — Major Sites Diagnosed and Treated at AMC during 2010

By Age

![Breast Cancer Cases by Age](chart)

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**Bladder — Major Sites Diagnosed and Treated at AMC during 2010**

By Age

By Gender

**Colon / Rectal — Major Sites Diagnosed and Treated at AMC during 2010**

By Age
**Colon / Rectal — Major Sites Diagnosed and Treated at AMC during 2010, continued**

By Gender

By Age

**Lung — Major Sites Diagnosed and Treated at AMC during 2010**

By Age

By Gender
Prostate — Major Sites Diagnosed and Treated at AMC during 2010

By Age

![Bar Chart]

- 40-49: 1 case
- 50-59: 10 cases
- 60-69: 14 cases
- 70-79: 7 cases
- 80-89: 5 cases
Role of the Appointed Commission on Cancer Liaison Physician

Frances Ting, MD

Cancer Liaison Physician are leaders of the cancer program by demonstrating a strong commitment to the success of the program, by providing leadership and support to the Commission Approvals Program, and other Commission on Cancer activities at local facilities. The Cancer Liaison Physician is an active member of Adventist Medical Center (AMC) Medical Staff, Cancer Committee, and Cancer Conference member.

During the course of the 3-year term, the Cancer Liaison Physician is responsible for leading CoC initiatives in their cancer program in many ways:

- Collaborating relationships with the ACS
- Supports and works collaboratively with Cancer Data-Registry staff; continually monitors cancer data for quality
- Dedicated to the development and monitoring of community outreach activities, including prevention and early detection programs with the interests of cancer patients, cancer care in the community, and the overall improvement of the quality of care for the cancer patient
- Participate in the Commission on Cancer accreditation process

Adventist Medical Center wishes to express our gratitude to Dr. Frances Ting who began her term of Liaison Physician to the Cancer Program January 2010.

Cancer Conferences

Rebecca Orwoll, MD

Program Activity Coordinator

Cancer Conferences are essential to improving the care of cancer patients by contributing to the patient management process and outcomes. Bi-monthly, medical and radiation oncologists, surgeons, pathologists, radiologist, primary care physicians, other specialty medicine physicians, and supportive services join as a multidisciplinary team to review each patient’s clinical and cancer history. The most current diagnostic and treatment pathways including the National Comprehensive Cancer Network (NCCN) guidelines, as well as cancer staging and clinical research trials, are actively reviewed in the decision-making management of the patient’s treatment plan. Cancer Conferences also serve to provide education to physicians and other allied health professionals.

Adventist Medical Center Cancer Conferences are held on the second and fourth Tuesdays of each month, from 12:00 pm to 1:00 pm.

Medical Imaging

Dale R. Nance, MD

The Medical Imaging department continues to explore ways to better serve the attending physicians and oncology patients here at Adventist. One of the goals has been to improve convenience and access for patients to the diagnostic imaging services. Consequently, more of our services are now being provided in an outpatient setting. At Professional Building 3, we feature digital radiography, mammography, ultrasound and DEXA. This move has been well received, and has definitely improved patient convenience.

The outpatient radiology services at Gresham Station have been improved as well by a decision to have the facility staffed by a full-time radiologist. On site consultation with clinicians and patients alike is now readily available. In addition, the presence of a radiologist at Gresham Station has enabled us to offer ultrasound-guided breast biopsy in addition to the MR-guided biopsy procedures, which we have already been providing. This further complements a busy outpatient mammography service at the facility.

In 2009, the radiology department added a Siemens dual source CT which has enhanced the speed and accuracy of performing exams and allowed us to offer a robust CT angiography service as well.

Interventional Oncology / Radiology:

As we enter 2011, we are making a continuing effort to make the medical staff aware of the potential role of interventional radiology as part of the multidisciplinary approach to treating oncology patients. In other facilities, it is frequently used as an ancillary procedure to more traditional radiation and chemotherapy treatment protocols.

Broad categories of IR treatment options include the following:

1. Transcatheter arterial embolization: (particularly used with primary and metastatic liver disease)
   - Chemoembolization in which a combination of high dose chemotherapy and an arterial occluding agent are selectively injected into vessels feeding the tumor site. Drug-eluting microspheres are another option.
   - Yttrium-90 radioablation (delivered in a similar manner to chemoembolization).
   - Also used to control bleeding related to tumor, regardless of site.

2. Radiofrequency Ablation (RFA):
   - RFA is a non-surgical, localized treatment involving placement of an RFA probe, under CT or US guidance, which kills the tumor cells with heat.
   - Initially used with hepatic malignancies, it is now an option with small, exophytic renal cell carcinomas, as well as certain bone and lung tumors.
3. Pain control in oncology patients:

- The second most common indication for vertebroplasty is for pain control and vertebral body stabilization in patients with metastatic disease to the spine. Generally, this results in prompt relief and does not interfere with subsequent radiation therapy.
- CT-guided celiac plexus ablation for long-term pain control in patients with upper abdominal malignancies (including gastric and pancreatic carcinomas).

The vast majority of IR related treatment for oncology patients is available here at Adventist Health. Seldom should it be necessary to refer such patients to a separate facility for these procedures.

**Pain Management**

*Oleg Maksimov, MD*
*Columbia Pain & Spine Institute*

Approximately 30% to 50% of people with cancer experience pain while undergoing treatment, and 70% to 90% of people with advanced cancer experience pain (Lesage P. and Portenoy RK. Cancer Control; Journal of the Moffitt Cancer Center 1999; 6(2):136-145).

Pain is usually well controlled and managed by primary care physicians and oncologists. Some difficult cases require consultation of pain management physicians. Expert level of opioid medications management may involve significant dose advancement with strict monitoring of the side effects. When risks of side effects of opioid medications overpower the benefits of pain relief produced by opioid, other usually more invasive options are applied under the direction of pain specialist. Advanced options in treatment of uncontrollable cancer induced pain include injections of steroids around inflamed structures, chemical and electrical denervation of nociceptive or neuropathic source, and vertebral augmentations for spinal neoplastic fractures, spinal cord stimulators, and intrathecal opioid delivery devices.

Pain is a common associated cancer symptom and should be addressed diligently. With the advancement of pain management, we can further decrease pain and allow the patient to enjoy the family, hobbies, and life.

**Hospice & Outpatient Palliative Care**

*Scott Smith, MD*

Our hospice program continues to be a center of excellence in end-of-life care. Adventist Hospice is a team of highly skilled, experienced and dedicated professionals led by two full time medical directors who are actively involved in all aspects of the day to day medical management of our patients and provide direct patient care with home visits. Patients, their families and care givers benefit from an interdisciplinary approach to care that focuses on achieving the greatest possible quality of life in the face of severe illness. A nurse case manager makes regular home visits and coordinates the involvement of the other team members including social workers, chaplains, home health aides, and our full time physical therapist, as well as music therapy, massage therapy and bereavement services. This past year we have been able to expand our scope of services to include out-patient palliative care. Health Options is a program in collaboration with CareOregon. This program is led by Laura Macias RN and provides nursing, social work, chaplain and home health aide services to patients with life limiting illness who are not yet eligible for hospice services or patients continuing to receive active treatment for a terminal illness.

Our Adventist Health Hospice team is dedicated to providing physical, emotional and spiritual comfort to patients and families with the comprehensive support that is essential to face the end-of-life journey with dignity and confidence.

**Pathology/Laboratory**

*Meredith Peake, MD*

The Adventist Medical Center (AMC) Pathology Department examines specimens to identify and classify various neoplasms, including surgical specimens, bone marrow samples and samples from various tumors obtained by fine-needle technique, with or without radiological guidance. A full range of routine and immune-mediated diagnostic tools are available, either on site or through consulting and referral laboratories, such as Oregon Health Sciences University, commercial laboratories, and others.

Staff pathologist qualifications at AMC include board certifications in Anatomic Pathology, Clinical Pathology, Cytopathology, Dermatopathology, and Hematopathology.

Automated immunohistochemistry is used routinely to classify and/or confirm tumor diagnoses, which usually results in far shorter turnaround times for reports than was the case in the past. Most reports are obtainable on-line, so there is no delay by paper handling.

Tests for chromosomal abnormalities found in neoplasms are increasingly in use as an aid in planning chemotherapy and radiotherapy, and are available upon request. A number of molecular studies are performed automatically to provide treatment information: Her-2 amplification in breast cancer, EGFR mutation in adenocarcinoma of the lung, and KRAS mutation in colon adenocarcinomas. Flow cytometry is also utilized to characterize hematologic abnormalities, including lymphomas, leukemias and myeloproliferative disorders.

The role of genetics is also increasingly being addressed by pathologists. Tests for mismatch repair genes are automatically performed on patients who are diagnosed with colon or endometrial cancer under the age of fifty to detect Hereditary Nonpolyposis Colorectal Cancer (HNPCC) or Lynch Syndrome. Once identified, these patients can be referred to an oncologist or cancer genetics counselor for appropriate counseling and screening tests to detect future malignancies.
Radiation Oncology

Kim Earp, MBA, RT(R)(T)

New Equipment
The Radiation Oncology Department at Adventist Medical Center was very pleased to announce the purchase of two new linear accelerators in early 2011. This equipment will allow us to visualize tumor targets prior to treatment. This technology is called Image Guided Radiation Therapy (IGRT) and represents the most current advances available in the industry. Some shielding changes are required and the equipment is scheduled to begin use by early June 2012. This acquisition represents Adventist’s ongoing commitment to provide the highest quality care in a patient-centered environment.

Enhanced Care
Our patient evaluations show a continued high degree of satisfaction with the care received. The average score for all patients completing a survey was 4.7 on a 5-point scale where five is “Highly Satisfied.” Our mission is to provide state of the art radiation therapy in a compassionate and supportive environment.

Integrated Support Services
The Radiation Oncology Department relies on the excellent supportive care team available at AMC. Our social worker, Thomas Crawford, MSW, chaplain, Pam Proudfit, and dietitian Melva Adkins regularly attend our weekly patient care meetings. These professionals have contributed to the whole person care that is part of our mission. The Radiation Oncology Department is continuing in its commitment to bring the highest quality of compassionate care to our patients.

Role of the Cancer Care Coordinator

Teri Gilmore, RN, BSN, OCN

Patient navigation programs are designed to reduce disparities in cancer treatment. Our program began during November 2009. With increasing physician referral and direct request from patients themselves, my work has expanded beyond supporting the newly diagnosed, to include women with metastatic disease as well as many in long term follow-up after completion of adjuvant treatment. The number of women served has grown dramatically with nearly 300 women receiving some type of support during 2011, almost three times that of 2010.

My over-arching goal is to enhance breast cancer screening, diagnosis, and treatment by identifying and removing potential barriers to care, and to provide patients personalized assistance in culturally appropriate ways. I serve as educator, coordinator, advocate, compassionate sounding board, and facilitator. Women with breast cancer have many needs. Individual needs are as diverse as the women themselves.

Services include:

- Reinforcing information provided by physicians;
- Ensuring timely coordination of care;
- Teaching to prepare and recover from surgery;
- Help women obtain appropriate post-surgical bras;
- Teaching post-surgical stretching exercises to encourage full return to baseline range of motion;
- Help managing side effects of treatments;
- Locating resources and support systems;
- Facilitate communication with health care staff and providers;
- Identifying financial resources to help patients pay for their health care;
- Help decrease patient’s fear and anxiety;
- Track interventions and outcomes;
- Coordinate American Cancer Society services at AMC: Look Good Feel Better and the Wig Gift Closet.

Cancer Clinical Trials

Beth Johnson, RN

Adventist Medical Center continues an affiliation with the Columbia River Oncology Program (CROP). CROP is supported through the Clinical Community Oncology Program (CCOP) of the National Cancer Institute. The Columbia River Oncology Program is dedicated to the goal of enhancing the health of our community by providing and promoting cancer treatment, prevention and control research. The Clinical Community Oncology Program allows large NCI-funded studies to be implemented at the community level. A CROP committee selects the NCI clinical trials that CROP investigators may choose to participate in. CROP had approximately 60 treatment and cancer control trials available in 2010. Patients continue to be followed on clinical trials at Adventist Medical Center.

Not all trials match the particular disease site for an investigator’s patient population. Other barriers for trial participation include investigator interest, stringent eligibility requirements for patient enrollment, small number of registered investigators and fewer clinical trial tests/procedures covered by the protocol or patient’s insurance.

While there are many obstacles in place, patients continue to be screened for eligibility to participate in clinical trials. All patients presented at the twice-monthly cancer conferences have been screened for possible clinical trial accrual. Physician and patient education about clinical trials at Adventist Medical Center continues to be a program goal. The Clinical Trials office can be reached at 503-261-6673.
Specialty Rehabilitation

Heather Saviage, OTR/L

- Women’s Health
- Chronic Pain
- Lymphedema

Physical therapy in the Specialty Rehab clinic is designed to meet the needs of many types of cancer patients, as well as other diagnoses.

Post-surgical Breast Rehabilitation — This therapy is designed for women who have undergone any type of breast surgery including:

- Mastectomy
- Radiation
- Reconstruction
- Augmentation
- Lumpectomy
- Biopsy
- Reduction

For those now experiencing pain, discomfort, weakness or a reduction in range of motion as a result of surgery, Physical Therapy can help. Early intervention may prevent a simple problem from becoming severe. Treatment has been shown to be effective even several years after surgery.

Lymphedema Treatment — A common complication associated with cancer is the swelling of the arms or legs that results from damage to the lymph system.

Lymphedema has many possible causes that include:

- Removal of lymph nodes
- Radiation therapies
- Stroke
- Vascular surgeries or conditions

The proper treatment of lymphedema incorporates the use of special wraps and massage techniques to restore normal function and reduce swelling.

Chronic Pain Therapy — Postural dysfunction and pain in the spine and sacroiliac joint and/or pelvis may be relieved through myofacial release, muscle energy techniques, soft tissue and joint mobilization. Some common diagnoses for this type of therapy are:

- Fibromyalgia
- Muscle and joint pain
- Headaches

Post-surgical scar restrictions
- Neck/throat cancer patients

Specialty rehab services are available at the Adventist Health outpatient clinic only.

Occupational Therapy

Heather Saviage, OTR/L

Occupational therapy provides individualized treatment focused on helping cancer patients be independent with daily living skills which include work, family, and self care. Occupational therapy provides service in acute care as well as outpatient locations. Treatment can include:

- Adaptive equipment for daily living and work
- Patient/caregiver education
- Energy conservation
- Hand therapy
- Splinting

Audiology Services

Gregory Borgmeyer, AuD, CCC-A
Erika Jones, AuD, CCC-A

The Audiology Services Department provides hearing assessment services to patients who may lose their hearing due to chemotherapy. Hearing loss may be overlooked in the diagnosis and treatment of cancer and can have a significant impact on a patient’s quality of life.

High frequency monitoring of hearing during ototoxic drugs or radiation therapy in the head and neck region is available for cancer patients, as are full hearing evaluations or hearing screenings.

Our services include:

- Ototoxicity monitoring
- Individual hearing screenings
- Full diagnostic hearing evaluations

Speech Therapy

Amy Burkard, MS-CCP, SLP

Speech and language pathology services include providing support for cancer patients and their families through all the service delivery areas of the Adventist Health system. These include inpatient and outpatient services at Adventist Medical Center as well as through home health services.

Treatment plans are personalized to the patient’s needs which can include assistance with selecting appropriate diet textures, assistance in swallowing, as well as with assessment for a voice prosthesis or
developing a nonverbal communication aid if necessary. Our goal is to keep oral intake comfortable and communication abilities functional. Services include:

- Working with dietary services to assure that food textures are easy to swallow.
- Assisting family members and caregivers in feeding techniques to avoid choking or aspiration.
- Evaluating and promoting treatment to establish a laryngeal post-laryngectomy communication.

**Physical Therapy**  
*Donald R. Montgomery, PT, DPT, OCS*

The Physical Therapy Department provides individualized care for all cancer patients both in our acute care setting and outpatient service locations.

Treatment techniques may include:

- Functional mobility
- Gait, balance and transfers
- Strength and endurance training
- Pain relief
- Equipment needs

Adventist Health Balance & Mobility Center is designed to evaluate those at risk for falls. Treatment programs are specific to diagnosis.

**Pastoral Care**  
*Pam Proudfit, MDiv, BS, Chaplain*

A cancer diagnosis brings changes in a patient’s relationships, roles, and priorities. One’s strengths and fears, resources and hopes may be re-examined, and many aspects of life have new spiritual significance. In the context of living with or dying from cancer, a person’s internal response can be in tension with his/her values and beliefs. Chaplains are available to help process these issues and access meaningful resources. Pastoral Care services address people’s needs in some of the following ways:

- **Pre-Operative** visits are made to patients prior to a surgery that requires an overnight stay.
- **In-Patient** visits are made by chaplains, as part of the treatment team, unless requested not to do so.

Referrals may come from physicians, nurses and other hospital staff, as well as from a patient or family.

**Cancer Conferences** are attended by a chaplain twice a month. This enables the chaplain to be better informed regarding the medical challenges that confront cancer patients and to present social/spiritual considerations when appropriate.

**Radiation Oncology** chart rounds are attended by a chaplain, who is available to offer spiritual support as requested by a patient or staff.

**Hospice Chaplains** are available to all of Adventist Health Hospice patients and families. Between 60 percent and 70 percent of patients request and receive continuing pastoral care. Two full-time chaplains are members of Hospice’s interdisciplinary team and contribute to care planning.

**Home Health** patients receive a packet containing a letter of introduction and an invitation to be visited by a chaplain. Adventist Medical Center’s Pastoral Care offers up to five hours per week for chaplain services to home health patients and inter-disciplinary team meetings.

Response at time of death is made as chaplains are notified, whether the patient is in the hospital or at home under hospice care. They provide emotional and spiritual support to family and friends, and to staff.

**Funeral Services** are sometimes officiated by chaplains, who may also attend memorial services of hospice, home health and hospital patients with whom they have become acquainted.

**Bereavement Support** is offered through a six-session Healing Grief class four times a year. Also, a sympathy card offering a memorial Bible is sent to families of patients who die in the hospital. Additional support is given as they respond.

**Staff Orientation and Support** is provided by the Pastoral Care department to nursing and ancillary personnel regarding spiritual care. Within the provisions of AMC’s mission statement, the pastoral staff supports each health care giver’s own spirituality and extension of that spirituality in addressing patient needs.

**Oncology Nursing**  
*Heather Goold BSN, OCN*

The Medical/Oncology Nursing unit provides services for both inpatient and outpatient populations at AMC. We have two nationally certified nurses, Heather Goold and Marie Pieren. Oncology Certified Nurses (OCN) are required to complete continuing education by attending national or community conferences, online courses and hospital provided in-services. Three nurses maintain the ONS Chemotherapy and Biotherapy Certification.

In 2010 several nurses independently attended local conferences. Several staff attended the Oregon Hospice and Palliative Care Annual Conference in June.
The Palliative Care Program, developed and run by Karen Johnson BSN, CHPN, strives to meet the many complex needs of our patients and families throughout their experience with chronic illness. The program also supports the Physicians and Nursing staff with one on one education/counseling, debriefing support, and in-services.

We continually update our educational material, providing patients and families with the information related to specific cancer diagnosis, symptom management and available resources.

We maintain membership in the Oncology Nursing Society (ONS), which provides our unit with up-to-date literature on standards of care, current treatments, therapy practices, and national journals. Examples of our national journals are: Oncology Nursing Forum, and Clinical Journal of Oncology Nursing.

We maintain membership with the Adventist Health Cancer Committee, Radiation Safety Committee, the Palliative Care Steering Committee, the Nurse Advisory Council, and the Oncology Work Group. These resources provide our staff with opportunities to network with other health care professionals. This valuable information then allows us to implement “best practice” with both local and national current standards.

**Continuing Education Classes 2010**
- Palliative Care – Karen Johnson, Palliative Care Coordinator
- Radiation Safety – Kim Earp, Radiation Oncology
- Huddle In-services – Marie Pieren
- Education Express – Health Stream (online)
- AMC’s Oncology Nursing Consortium – Heather Goold, Marie Pieren (in development)

**Pharmacy**
*Janice Hogue, RPH*

The pharmacy department provides 24-hour clinical and distributive oncology services. Pharmacists and Pharmacy IV Admixture Technicians are highly trained to safely and accurately prepare chemotherapeutic agents and associated medication therapies. Pharmacists oversee special protocols and safety procedures for preparation, dispensing, administration and disposal of chemotherapy. Clinical literature, reference manuals, and a computerized clinical information system provide the most current clinical information for pharmacy staff.

**Nutritional Services**
*Melva Atkins, RD, LD*

The Clinical Nutrition staff continues to be committed promoting the nutritional well being of our cancer patients. Registered Dietitians routinely visit and counsel with patients and their families at the time of diagnosis through the course of their treatment. Our services cover inpatients, outpatients, home health patients and Radiation Oncology.

The dietitians provide counseling and education on maintaining adequate oral intake. Help with assessing and monitoring patients for more specialized nutrition support is available should it be necessary. Adequate nutrition is a key component to the success of many other therapies provided to the cancer patient. We work closely with the other allied health services to coordinate care plans. Our goal is for the patient to safely maintain oral intake as long as possible and be as well nourished as possible at the end of their treatments. Our outpatient dietitians take an active role in counseling the patients receiving Radiation Therapy. Referrals can be made to the home infusion dietitian, to counsel and monitor patients receiving home nutrition support.

The past decade has brought increased knowledge of possible causes of cancer. It has also brought information on the potential benefit of certain nutrients that may have a protective benefit. When appropriate, our dietitians will instruct patients on how to safely incorporate these foods or supplements into their diets.

**Home Health**
*Susan Erich, RN*

Home Health provides a team of health care specialists including nurses, Home Health aides, physical, occupational and speech therapists, and social workers who work with patients and their families to teach them self-care or how to care for an ailing loved one. Our nurses perform both simple and complex procedures, including wound care and intravenous administration.

This program is an integral part of the continuum of care for those patients discharging from the hospital but still needing nursing or therapy services. It is also to keep those from an intermittent stay in a skilled nursing facility. All of these services are available for patients who are home bound, or find it difficult to leave home, and for whom restorative care is deemed appropriate by the physician. The goal of home health is to enable patients to stay in their homes and be as independent as possible.

**Social Work**
*Terry Dion, LCSW*

Coping with cancer is far more than a physical or medical process. Alterations in emotional well being, social relationships, and spiritual outlook often accompany the illness experience. Treatment needs may come to dominate daily life, competing with or replacing other significant activities, such as work and family time. Access to community and financial resources, such as in-home assistance and disability income, may become necessary.
Medical Social Workers are uniquely qualified to address the psychological and emotional needs presented by patients with cancer and their loved ones. Social work support is available to persons served within and beyond the hospital.

Hospital discharge planners assess patient and family needs in order to facilitate optimal discharge. In the home environment, Home Health, Radiation Oncology, and Hospice Social Workers assist patients and their families with community resource linkage and much needed emotional support. Social work support including providing emotional support as well as to provide information on community resources is now offered to patients and their families in the Radiation Oncology Clinic collaborating with/supporting the work of our Patient Navigator, Teri Gilmore.

The Social Workers are an active part of the interdisciplinary team to assure that all of the patient’s needs are being met. As part of Adventist Medical Center’s commitment to care for the whole person — body, mind, and spirit — there is a support group for persons with cancer, and their loved ones. The focus of this group is to provide persons with cancer and their loved ones a safe place in which to discuss concerns, share information, and offer support to one another.

**Palliative Care**  
*Karen Johnson, RN, BSN, CHPN*

The Palliative Care Program provides services for our in-patient population, focusing on promoting Quality of Life for patients living with advanced, chronic and/or life limiting illnesses and their families.

Palliative Care serves those anticipating curative intervention at discharge as well as those transitioning to hospice or those dying here in the hospital.

Palliative Care offers assistance with:
- Symptom management
- Patient and family emotional or spiritual distress
- Goals of care review
- Helping patients and families understand the severity of the disease
- Information about their disease and hospitalization
- Advanced Care Planning
- Coping with new life-limiting diagnosis
- End-of-Life care
- Transitioning from the in-patient setting across the continuum of care

AMC Palliative Care also works to provide education for staff. Palliative care educational opportunities in 2010 included:
- Statewide Palliative Care Conference, “Hope and Acceptance: The Human Struggle”
- Hosting the All-City Palliative Care Conference in April entitled, “When values collide: Hope, miracles and grave prognosis,” and in October entitled, “Improving the Quality of Spiritual Care is a Dimension of Palliative Care.”
- Education at Medical Unit huddles (quarterly) on requested Palliative Care topics
- 1:1 staff education during patient care
- Presentation, “AMC Ethics Consultation”
- Center to Advance Palliative Care audio conference, Audio-Conferences, “The Palliative Care/Critical Care Nexus,” and “The Palliative Care Social Worker: Opportunities for Collaboration, Triage, Education and Outreach.”
- “Equianalgesia and Titration of Opioids,” Fall Ed Ex

**Wellness Services**  
*Edward Hoover, MA*

Since 1963, Adventist Medical Center has been committed to helping smokers break free from the powerful addiction to nicotine. In addition, in keeping with our Adventist Health heritage and modern research we have continued to share some of the many benefits of a plant-based diet, personal fitness and other recognized approaches to cancer risk reduction.

**Smoking Cessation**
Weekly Support Group Meetings: Social support is critical for the recovering nicotine addict. For over 30 years this one-hour support group has met on Monday evenings. Although primarily for recovering smokers, these free sessions are open to anyone considering quitting. Attendance continues to vary between eight and 15 people each week.

**Nutrition & Fitness**
Vegetarian Nutrition Promotion: Throughout the year, Wellness Services offers workshops, educational displays, screening events and other materials designed to help improve awareness of the benefits of a balanced, plant-based diet. These efforts are often in partnership with the National More Matters Campaign — promoting fruit and vegetable consumption, American Cancer Society, The Cancer Project, and the American Institute for Cancer Research.

**Preventive Health Screening & Education**
An ongoing dimension of Wellness Services has been our work with conducting health screenings and cancer prevention education in a number of community and workplace settings. These often include a variety of cancer-related screenings including skin cancer checks,
occult blood, PAP, and PSA screenings. Because of its relationship to cancer risk and the high incidence of low vitamin D levels in the region, vitamin D screening and education continues to be popular.

Inquiries and referrals can be made by contacting Wellness Services at 503-261-6611.

**Cancer Patient Transportation Program**

*Kimberly Earp, MBA, RT (R)(T)*

The Cancer Patient Transportation program is a mission driven program for Adventist Medical Center (AMC). This service is funded substantially by charitable contributions from AMC staff. Patients requiring transport are identified based on referrals from physicians and other staff. The program provides transportation for ambulatory patients who have no other means of transportation to and from radiation therapy appointments or other hospital imaging procedures. The program has paid, part-time employees who coordinate the transportation between the patient and Radiation Oncology.

This program helped transport 23 patients in 2011 for 497 trips. The quantitative evaluation of their efforts cannot sufficiently emphasize the tremendous impact these drivers have in the lives of patients and families. Without their help, many families would have to choose between, working income and insurance versus assisting spouses and ailing family members. This program is tremendously important in the lives of patients and also gives drivers a sense of satisfaction in helping others. We are grateful to the generous staff of AMC for supporting this program.

**Clinical Nurse Specialist,**

**Ostomy and Wound Care**

*Linda Henry, RN, MS, CNS, WOCN*

Clinical Nurse Specialist, Ostomy and Wound Care Services for patients at Adventist Medical Center provides preoperative counseling and stoma marking; fitting of appropriate ostomy appliances; instruction and support for patients and families in ostomy care, including some of the newer ostomy surgery options; troubleshooting for appliance, skin care, and leakage difficulties; radiation skin care; and instruction and assistance for fistula problems that can be managed with ostomy pouches. Both inpatient and outpatient services are available for ostomy patients. Outpatient services, preoperative consultation, early involvement and communication with the home health and hospice team are necessary to provide care and accomplish goals in the short hospital stay.
our mission

. . . to demonstrate the human expression of the healing ministry of Jesus Christ.

We commit to:

- Delivering whole-person care that nurtures body, mind, and spirit;
- Encouraging living well by promoting a healthy lifestyle;
- Reflecting God’s love by serving with compassion, dignity and respect;
- Improving the health of the communities we serve;
- Providing services in the most medically and financially appropriate setting;
- Delivering compassionate, high quality care with technical excellence;
- Creating a safe environment of care that inspires trust and confidence;
- Serving as a faith-based health care organization consistent with the philosophy of the Seventh-day Adventist church;

our vision

We will be the market leader in delivering innovative, accessible, cost-effective, high quality, whole-person care. We will be recognized for exceptional service consistently demonstrating our mission and values.

our values

In partnership with God, we will fulfill our mission and vision by treating others in harmony with our values:

- **Integrity** – Ensure our actions are consistent with our values
- **Quality** – Provide care that is safe, reliable and patient-centered
- **Compassion** – Reflect the love of Jesus through care, respect and empathy
- **Wholeness** – Embrace a balanced life – integrating mind, body and spirit
- **Respect** – Recognize the God-given dignity and individuality of each person
- **Family** – Support each other in achieving our shared purpose
- **Stewardship** – Serve our community through responsible resource management