Cancer Committee Roster 2011-2012

CANCER COMMITTEE CHAIRMAN
Mark Seligman, MD
Internal Medicine / Hematology / Oncology

CANCER PHYSICIAN LIAISON
Frances Ting, MD
General Surgery / Breast Surgery

QUALITY IMPROVEMENT COORDINATOR
Wesley Rippey, MD
General Surgery / Vascular Surgery

CANCER CONFERENCE COORDINATOR
Rebecca Orwoll, MD
Internal Medicine / Hematology / Oncology

MEDICAL STAFF REPRESENTATIVES
Drew Chen, MD
Internal Medicine / Hematology / Oncology

David Goldberger, MD
Internal Medicine

Vincent Hansen, MD
Family Physician

Aaron Hicks, MD
Radiation Oncology

William Kennedy, MD
Medical Director, Hospice / Palliative Medicine

Jin-Hee Kim, MD
Urology

M.C. Theodore Mackett, MD
General Surgery / Vascular Surgery

Dale Nance, MD
Radiology / Interventional Radiology

Meredith Peake, MD
Chief of Pathology

Arnold Petersen, MD
Obstetrics / Gynecology

Jed Peterson, MD
Radiology / Interventional Radiology

Kraig Russell, MD
Hospice / Palliative Medicine

Kathryn Shell, MD
Internal Medicine / Hematology / Oncology

Scott Smith, MD
Hospice / Palliative Medicine

CANCER DATA SERVICES
Laura Wallace, RHIT, CTR
Cancer Program Coordinator
Cancer Data Management / Registry

Tomsi Logan
Cancer Program Assistant

Melva Atkins, RD, LD
Nutritional Services

Thom Crawford, ACHP-SW
Social Work

Terry Dion, LCSW
Social Work

Kim Earp, RT (R) (T), MBA
Chief Therapist, Radiation Oncology

John Ferguson, CRA, MBA
Director, Medical Imaging

Teri Gilmore, RN, BSN
Breast Cancer Care Coordinator

Heather Gooch, BSN, OCN
Oncology Nursing

Melissa Grosso, RHIA
Director, Health Information Services

Pam Heiser, RN, MBA
Vice President

Linda Henry, RN, MS, CNS, WOCN
Clinical Nurse Specialist

Cindy Hiday, RN
CPI Coordinator

Janice Hogue, RN
Director, Pharmacy

Ed Hoover, MA
Community Outreach Coordinator
Manager, LivingWell / Community Wellness

Beth Johnson, RN
Clinical Trials Nurse / Radiation Oncology

Karen Johnson, RN, BSN, CHPN
Palliative Care Coordinator

Eric Livingston
Physician Liaison

Cindy Nutter, RN
Director, Inpatient Units

Pam Proudfoot, MDiv, BS
Chaplain

Gretchen Renggli
American Cancer Society

Heather Savage, OTR/L
Specialty Rehabilitation / Occupational Therapy

Dave Tkachuck
Director, Home Care

Dulcie Ward, RD
Nutritional Services

Acknowledgements

Special thanks to:
Aaron Hicks, MD
Jeffrey Boskind, MD

From the Cancer Data Services Staff:
Laura Wallace, RHIT, CTR
Tomsi Logan

This report is produced by Adventist Medical Center’s Cancer Registry and the Marketing and Communication Department. The production of a cancer program annual report is in compliance with the requirement of the American College of Surgeons Commission on Cancer.

To contact us, write to: Adventist Medical Center – Cancer Registry, 10123 SE Market Street, Portland, Oregon 97216.
Chair’s Report

The Cancer Committee of Adventist Medical Center is charged with bringing the values of the Adventist mission of health to persons suffering from or at risk of neoplastic diseases. These values are Integrity, Quality, Compassion, Wholeness, Respect, Family, and Stewardship. Achievement of such lofty ideals is not a job that one person can do, but it requires a team. At Adventist we are proud to have a team comprised of doctors, nurses, technicians, pharmacists, social workers, pastors, and counselors that can and do provide the full spectrum of modern medical care which includes active community outreach to teach and instruct in life choices that will prevent disease in the first place.

We know that we owe the community an accounting of our activities to show that we are doing the things that we have been charged to do. In this spirit, we offer this report. For this year we are presenting our 2011 lung cancer statistical data with comparative national data reported from the most recently available data. It shows that we are doing a very good job in this disease. It is harder to show the people who have been saved from this illness in the first place by our health outreach efforts, but we are very proud of those efforts and back them fully.

We are proud of the hard work done by our colleagues whose reports are enclosed within these pages. Their dedication is real and inspirational. The unnamed staff who do the daily toil of the hospital and health mission also deserve our gratitude and respect; they are all important. Not the least of the important contributors to the hospital are the volunteers and donors who do so much.

Lastly, we would like to recognize the administration which fosters an atmosphere in which important work is not just possible, but expected.

Mark Seligman, MD
Cancer Committee Chairman

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
Lung cancer continues to be the most common malignancy in the United States and is associated with the most cancer deaths annually compared to prostate, breast, and colon combined. Tobacco abuse continues to play a significant role in the etiology of lung cancer for both nonsmall cell lung carcinoma and small cell lung carcinoma. Thoracic surgical procedures continue to be the best option for early stage lung cancer. This includes stages IA–IIb. The five-year survivals for these are quite high, with some of them exceeding 90%. When one looks at those that die within the five-year followup, the majority are dying from natural causes or cardiac related issues. However, 10-15% are in fact dying of recurrent lung cancer.

The standard of care for early stage lung cancer remains surgical resection, however the type of resection has in fact changed. Segmental resection is increasingly being performed for early stage lung cancer. This is in contra-distinction to wedge resection which has a high recurrence rate and poor five-year survival due to recurrence and failure to control the carcinoma. Segmental resection is valuable because it is an anatomic resection and preserves lung parenchyma. It also provides similar five-year survivals compared to lobectomy. We at Adventist Medical Center have been performing large numbers of segmental resections for these reasons and to follow current oncologic guidelines/recommendation. We are taking the position to do a segmental resection if at all possible prior to performing a lobectomy.

Radiation therapy has made some significant changes in regards to lung cancer with better survivals than traditional radiation therapy. These results exceed five-year survivals of wedge resections. The radiation therapy options available to patients today have significantly helped those patients that are not surgical candidates because of significant medical co-morbidities. It is very important that the patient see a thoracic surgeon so that an accurate physiologic workup can be done to confirm that they are not a surgical candidate. The traditional bench marks used to determine whether a patient is a surgical candidate have changed due to data and information obtained from the lung volume reduction research and data. Segmentectomy as treatment for an early lung cancer, in a patient who cannot tolerate a lobectomy, carries a similar five-year survival. Overall, radiation therapy continues to play an important role in the treatment of lung cancer as a neo-adjuvant, adjuvant, and definitive modality.

Stage III lung cancer has made some important changes. Historically, stage IIIa lung cancer in particular, has been treated with definitive chemo-radiation. This is because the five-year survival for bi-modality therapy was no different than tri-modality when surgery was included. Now, early stage IIIa lung cancer, with limited mediastinal lymph nodes or single station lymph node involvement are being treated with chemotherapy and then resection. The five-year survivals are better than the traditional bi-modality data when the patients are appropriately selected and treated. Chemotherapy continues to be standard of care for small cell lung cancer. Chemotherapy continues to play an important role in the treatment of lung cancer and in those patients who are surgical candidates due to the ability to control and down stage the early status of stage IIIa lung cancer.

Screening for lung cancer has changed with the addition of the screening chest CT. It has been able to find asymptomatic early staged lung cancers. This would be a reasonable first test and is more powerful than a routine chest x-ray from a screening standpoint in a patient who has a tobacco pack history of greater than 15 pack years or is an active smoker, has a diagnosis of emphysema, and either has a personal history or family history of cancer. Debate continues as to whether screening for lung cancer actually has a positive impact on overall five-year survival. Data continues to support that it in fact does. Another issue is that it tends to find a significant number of indeterminate pulmonary nodules which are not cancers yet once they are found a procedure of some type is then undertaken to diagnosis the etiology. This obviously adds to risk, morbidity and cost.

Overall, lung cancer continues to have a large presence within the surgical, radiation, and medical oncologic practices. There continues to be strong support that multi-modality therapies provide better five-year survivals than single therapies. With better screening pathways hopefully we will continue to not only find lung cancers earlier but also positively impact the five-year survivals. Putting this into perspective,
only 25 – 33% of patients that seek thoracic surgical oncologic consultation are surgical candidates. The majority of those that are not surgical candidates are due to the advancement of the lung cancer by the time they get consultation. On average it only takes approximately 18 months for the incidental asymptomatic lung cancer to become symptomatic and by that time the majority of the patients are stage III or greater.

**Survival Based on Stage at Diagnosis**

Based on the National Cancer Data Base (NCDB), five year survival rate for all patients diagnosed with any type of cancer is 68%. A mere 15% of small cell lung cancers are diagnosed at early stages. The five-year survival rate is significantly less as shown in the table below.

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

<table>
<thead>
<tr>
<th>Stage</th>
<th>AMC (cases)</th>
<th>NCDB (cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>32</td>
<td>57,946</td>
</tr>
<tr>
<td>II</td>
<td>54</td>
<td>84,917</td>
</tr>
<tr>
<td>III</td>
<td>81</td>
<td>141,688</td>
</tr>
<tr>
<td>IV</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Stage I**

- AMC: Insufficient cases to display survival information
- NCDB: 57,946 cases

**Stage II**

- AMC: Insufficient cases to display survival information
- NCDB: 19,894 cases

**Stage III**

- AMC: (54 cases)
- NCDB: 84,917 cases

**Stage IV**

- AMC: (81 cases)
- NCDB: 141,688 cases
Lung cancer is an exceedingly common disease. Over 250,000 people will be diagnosed with lung cancer this year in the United States. Lung cancer is also the most lethal malignancy causing more deaths than colon, breast and prostate cancers combined. More than 80% of cases are caused by exposure to tobacco smoke, suggesting that efforts at prevention could lead to a significant decline in the incidence of this disease.

Lung cancer can be divided into two main categories, non-small cell (NSCLC) and small cell (SCLC) lung carcinoma. NSCLC includes many different types of lung cancer such as adenocarcinomas, squamous cell carcinomas, bronchoalveolar carcinomas and others. Small cell lung carcinoma is less common, representing only 15% of all lung cancer diagnoses. However, it is a more aggressive malignancy, responsible for 25% of lung cancer deaths. The distinction between NSCLC and SCLC is critical because the recommended treatment is quite different.

The optimal treatment approach for an individual patient is based on disease features, such as type of lung cancer and stage, as well as various patient-associated factors, such as lung function and the presence of other illnesses. Therefore, recommendations for lung cancer treatment must be individualized and are best delivered through a team of specialized oncologists in a multidisciplinary setting.

Radiation therapy has a role in the treatment of all stages of lung carcinoma.

**Early Stage NSCLC**

Early stage lung carcinoma (stages I/II) is optimally addressed with surgical resection in patients deemed healthy enough to undergo an operation. Lobectomy (removal of a single lobe of the lung) is the standard of care and results in five-year overall survival (OS) of approximately 65% for stage I disease. However, selected patients with quite small primary lung tumors (less than 1.5 cm) may have five-year OS as high as 95%.

However, poor lung function, severe cardiopulmonary disease or other pre-existing medical illnesses may prevent a patient from safely undergoing a lobectomy. Treatment options for patients in this high-risk group include limited resections with either segmentectomy or wedge resection (removal of less lung tissue as compared to a lobectomy). However, surgical studies do show that cancer recurrence rates are higher after a limited resection as compared to lobectomy.

Non-operative approaches are also available to patients in this poor risk group, who are considered to be ‘medically inoperable’. Recent advances in technology have borne novel techniques for radiation delivery, including stereotactic ablative radiotherapy (SABR). With this non-invasive treatment, a six-week course of daily radiotherapy can be delivered in as few as three outpatient sessions.

A recently published study evaluated the outcomes after SABR in 55 medically inoperable patients with NSCLC tumors measuring less than 5 cm. The three-year tumor control was 98%, the three-year local-regional control was 87% and the 3-year OS was 56%, with a median survival (MS) of 48 months. There were no treatment related deaths and the risk of grade 3 and 4 (moderate and severe) toxicity was 13% and 4%, respectively. Multiple other studies, mainly from North America, Europe and Japan, have shown that for stage I disease, the ability to control the tumor locally is approximately 85% - 90%, with three-year survival of 45% - 60%. Given these encouraging results of SABR in medically inoperable patients, this treatment is currently being studied in operable patients with early stage lung cancer.

**Locally Advanced NSCLC**

Locally advanced NSCLC includes stages IIIA and IIIB in which primary lung tumor is locally advanced and/or has moved to the lymph nodes in the middle of the chest known as the mediastinum. When the involved lymph nodes are solely found on the same side as the lung tumor and/or appear in the midline (stage IIIA), then a three-pronged approach with radiation and chemotherapy followed by surgery can be considered in carefully selected patients. A large randomized controlled trial comparing this trimodality approach to concurrent chemotherapy with radiation showed that in these highly-selected patients, surgery improved the five-year progression-free survival from 11% to 22% with fewer local-only relapses (10% vs. 22%). Although the five-year OS was not statistically different between the two
treatments, there was a trend toward improved survival with surgery (27% vs. 20%). However, this gain came at the cost of increased treatment-related deaths with surgery (8% vs. 2%), particularly when removal of the entire lung (pneumonectomy) was performed.

However, many patients with stage IIIA disease and all of those with stage IIIB NSCLC are considered inoperable. Radiation alone has yielded disappointing results with a MS of only 10-12 months and five-year OS rates of 7%. Therefore, these patients are optimally treated with definitive radiotherapy along with concurrent chemotherapy. Numerous trials have been performed investigating the optimal sequence and timing of radiation and chemotherapy. Sequential regimens, with initial chemotherapy followed by radiation, improved outcomes over radiation alone, with MS ranging from 13-15 months. However, the results of multiple randomized trials have shown that the optimal timing is simultaneous chemotherapy and radiation, since chemotherapy sensitizes the cancer cells to radiation thereby improving the effectiveness of radiotherapy. The expected MS with a concurrent approach is approximately 18 months with five-year OS rates of 20% - 30%.

Advanced NSCLC (Stage IV)

Metastatic NSCLC is defined by lung cancer that has moved to the opposite lung, created fluid accumulation around the lung or heart (malignant pleural or pericardial effusion, respectively) and/or spread to areas outside of the chest. Common sites for metastases include the brain, liver, adrenal glands and bone. Although stage IV NSCLC is currently incurable, it is quite treatable and systemic chemotherapy is the cornerstone of therapy.

The role of radiation in this setting is palliative in nature, meaning that treatment may be delivered focally to address areas of clinical concern. Common examples in which radiation can be beneficial include: treatment of a lung mass that is obstructing an airway and causing shortness of breath; treatment of a malignant lesion eroding the mucosa of an airway and causing bleeding leading to coughing up blood; treatment of painful metastases to the bone; and addressing brain metastases. The majority of patients treated for the aforementioned reasons will experience some measure of relief from their symptoms following palliative radiation. Most of these radiotherapy courses can be delivered in 1-2 weeks, unlike the six-week regimens used in curative settings.

Small Cell Lung Carcinoma

Limited stage SCLC has historically been defined as disease confined to one hemithorax and/or regional lymph nodes. This is potentially curable with aggressive radiation and concurrent chemotherapy. The current standard is radiation delivered twice daily for three weeks. This resulted in a 5-year OS rate of 26% in the landmark study by Turrisi published in 1999. However, the optimal radiation dose and schedule is a current area of ongoing study.

Extensive stage SCLC is considered incurable and carries a very poor prognosis with 5-year OS of less than 5-10%. Chemotherapy is the mainstay of treatment. Occasionally, in well-selected patients who have an excellent response to chemotherapy, consolidative radiation is delivered to the primary lung lesion. However, this practice remains controversial and is based on the results of a single trial from Yugoslavia that showed a 5% absolute improvement in OS at five years (9% vs. 4%) when radiation was added to chemotherapy as compared to chemotherapy alone.

In patients with either limited or extensive stage SCLC, a well-accepted standard of care is the delivery of prophylactic cranial irradiation (PCI) in patients with good response to initial treatment. This results in improved survival as compared to patients who do not receive PCI. A meta-analysis of 7 trials evaluating PCI vs. no PCI in limited stage SCLC showed that PCI reduced the three-year incidence of brain metastases by nearly half (59% vs. 33%) and increased three-year OS from 15% to 21%. A well-conducted randomized study of extensive stage SCLC patients revealed that PCI reduced the one-year incidence of symptomatic brain metastases from 40% to 15% and improved OS from 13% to 27%.
Lung Cancer: Medical Oncology
by Rebecca Orwoll, MD

Only about 15% of lung cancers are small cell neuroendocrine type, with about 35,000 cases expected nationwide in 2012, and just 3 cases seem at Adventist Medical Center (AMC) in 2011. Small cell lung cancer is essentially always disseminated, even when observed tumor size is very small. The purpose of staging, therefore, is to plan combined modality treatment, and estimate prognosis. Thus for many years, chemotherapy has always been used, ideally concurrent with radiation therapy, or in rare instances, following surgical removal of small tumors. With this approach, initial response rates are very good, up to 90% with limited stage disease, and approaches 40% two-year survival. In extensive stage disease, response rates are still 60-70%, however two year survival is poor, generally under 5%, and long term survivors are rare.

The chemotherapy medications used for small cell cancer have not changed significantly recently, with carboplatin or cisplatin regimens generally used. A few other medications, such as temozolamide, topotecan, and irinotecan, have shown benefit, such that patients with various special circumstances have more options, and more options are available for recurrence. Neither maintenance treatments nor more complex regimens with alternating drug combinations have shown to be helpful. Clinical trials should be offered if at all possible.

Non-small cell lung cancer is much more common, with nearly 80 cases seen at AMC in 2011, and an estimated 226,000 cases nationwide expected in 2012, 85-90% associated with smoking. Lung cancer is the leading cause of cancer death worldwide. Overall only about 16% of these patients will be expected to be alive five years from diagnosis. Of great importance, patients with earlier stages of disease are more likely to be cured, with up to 52% five-year survival for localized disease, and even better in very early Stage IA and IB disease. Unfortunately, screening to discover more early stage cancer has only been shown to be helpful in select high-risk current and former smokers. Obviously, decreasing smoking behavior worldwide is the single most important strategy to decrease lung cancer incidence and death.

Detailed pathologic evaluation and molecular diagnostic testing is important to therapy selection. Endothelial growth factor receptor/EGFR, nucleotide excision repair complex/ERCC1, KRAS oncogene, and ALK fusion oncogenes, as well as other mutations, provide data including prediction of response to selected therapies as well as prognosis. Pathologists at Adventist Medical Center offer state-of-the art testing of lung cancers, guiding options for targeted therapies now available. For example, EGFR mutations seen in about 10% of Caucasian and 50% of Asian patients predict response to erlotinib and gefitinib, which can be as high as 80%, with erlotinib therefore first-line treatment instead of traditional chemotherapy in these patients. In contrast, resistance to these therapies is predicted by KRAS mutations and ALK gene rearrangements, however crizotinib benefits about 60% of patients with ALK rearrangements. Similarly, low levels of ERCC1 expression are associated with good response to platinum analogs. KRAS mutations predict shorter survival and resistance to targeted agents currently available.

There are a large number of chemotherapy agents with activity against non-small cell lung cancers. Medications are used preoperatively, concurrently with radiation, as adjuvant treatment after surgery, for treatment of widely metastatic disease, and as maintenance treatment. At the time of this writing, seventeen different agents are listed by the National Comprehensive Cancer Network/NCCN for non-small cell lung cancer. In fact, afatinib was just approved in the summer of 2013, for patients with EGFR mutations, emphasizing the importance of active development of new agents and participation in clinical research trials.

Primary care physicians, pulmonologists, radiologists, surgeons, radiation oncologists, medical oncologists, and pathologists at AMC work together to plan and provide the best available diagnostics and treatments for patients with lung cancer. In addition, AMC actively promotes smoking cessation programs and provides supportive care for all stages of the life of patients with this diagnosis.
Adventist Medical Center’s Cancer Data Services is a key component of the cancer program and is under the direction of Oncology Administration, the Cancer Committee and stringent compliance to the American College of Surgeons Commission on Cancer program standards.

Cancer Data Services is responsible for managing and analyzing clinical cancer data to collaborate with physicians, administrators, and health care planners to provide support for cancer program development, treatment, providing cancer incidence, and to ensure compliance of reporting standards.

Lung cancer is one of AMC’s top five sites. The overall prognosis for lung cancer is meager compared to other types of cancers. Overall five-year survival rates are approximately 16% compared to 65% for colon cancer, 89% for breast cancer, and 99% for prostate cancer. However, patients who are diagnosed when the primary tumor is resectable, experience five-year survivals extending from 20 to 80%. Clinical and pathologic staging is critical to determine patients accurately for surgery and multimodality therapy. Source: MedicineNet.com and AJCC 7th Edition.
Survival Rates

- The lung cancer five-year survival rate (16.3%) is lower than many other leading cancer sites, such as the colon (65.2%), breast (90.0%) and prostate (99.9%). *Source: U.S. National Institutes of Health. National Cancer Institute: SEER Cancer Statistics Review, 1973-2008.*

- The five-year survival rate for lung cancer is 52.6% for cases detected when the disease is still localized (within the lungs). However, only 15% of lung cancer cases are diagnosed at an early stage. For distant tumors (spread to other organs) the five-year survival rate is only 3.5%. *Source: Lung Cancer Fact Sheet.*

- Over half of people with lung cancer die within one year of being diagnosed. *Source: Lung Cancer Fact Sheet.*

---

**Lung — Diagnosis & Survival 2001-07**

Lung Cancer Diagnosis & 5-Year Survival

![Graph showing Lung Cancer Diagnosis & 5-Year Survival](source)

*Source: SEER Cancer Statistics Review, 1975-2008*
**Lung — Estimated Cancer Deaths 2012**

By Site

![Bar chart showing cancer deaths by site for 2012.](chart1)


**Lung — Cancer Incidence Rate, 1973 - 2008**

By Sex

![Line chart showing cancer incidence rate by sex for 1973-2008.](chart2)

Cancer Services

**Treatment**
- Surgery
- Chemotherapy
- Radiation Oncology
- Interventional Oncology/Radiology
- Hematology Services
- Cancer Specialty Rehabilitation
- Clinical Trials

**Diagnostic**
- Radiology Services
- CT Imaging
- MRI
- PET/CT
- Digital Mammography
- Ultrasound
- Skin Cancer Screenings
- Colonoscopies

**Support Services**
- Cancer Care Coordinator

<table>
<thead>
<tr>
<th>Pain Management</th>
<th>Wellness Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy</td>
<td>Specialty Rehabilitation</td>
</tr>
<tr>
<td>Lymphedema Clinic</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Audiology Services</td>
<td>Speech Therapy</td>
</tr>
<tr>
<td>Nutritional Services</td>
<td>Home Health</td>
</tr>
<tr>
<td>Social Services</td>
<td>Hospice &amp; Palliative Care</td>
</tr>
<tr>
<td>Nurse Specialist Ostomy Care</td>
<td>Management &amp; Instruction</td>
</tr>
<tr>
<td>Cancer Treatment Transport</td>
<td><strong>Staff Education</strong></td>
</tr>
<tr>
<td>Physician Cancer Lectures</td>
<td>Oncology nursing training</td>
</tr>
<tr>
<td>Lymphology Association of North America</td>
<td><strong>Program Activities</strong></td>
</tr>
</tbody>
</table>

**Support Groups**
- Cancer Support Group
- Breast Cancer Survivor Support Group
- Mammography Program
- Smoke Free Support
- Bereavement Support Group
- Hospice: Grief Support Groups & classes

**Educational Activities**
- Look Good, Feel Better American Cancer Society
- The Latest Nutrition Discoveries
- Creating Health Series
- Self-Help materials for Tobacco Cessation
- Computerized Health Risk Assessments
- Great Race Fitness Challenge
- LivingWell with Stress Series
- Web-based classes: weight, tobacco, nutrition, stress, etc.

**Community Activities**
- American Cancer Society’s Relay for Life
- Race for the Cure Expo and Walk
- Community & Worksite Screenings
- Plant-based Nutrition Conference
- Portland VegFest
- Better Living Show

When it comes to providing the best care to our community, Adventist Medical Center depends on your donations. Contact the Adventist Health Foundation team at 503-251-6197.