The Cancer Program at Kent Hospital

The Cancer Program at Kent Hospital offers a comprehensive range of services delivered by a dedicated team of professionals using the latest technology, offering patients and their families hope and compassion. A multi-disciplinary team of cancer professionals work with patients to create an individual treatment plan based on the diagnosis.

Services
Oncology care is provided by our 29-bed oncology inpatient unit, an outpatient chemotherapy/infusion unit and a full range of diagnostic imaging and laboratory services. Both oncology units feature an experienced team of physicians and oncology certified nurses.

The Cancer Committee at Kent Hospital meets quarterly to oversee the cancer program and to develop public education opportunities and community screening programs. Our cancer program is accredited with commendation by the American College of Surgeons Commission on Cancer as a Comprehensive Community Hospital Cancer Program, and also by the National Accreditation Program for Breast Centers which is dedicated to the improvement of the quality of care and monitoring of outcomes of patients with diseases of the breast. The mammography program was awarded the Breast Imaging Center of Excellence by the American College of Radiology.

Research
Kent's Cancer Program participates in a number of clinical research trials, offering cutting edge treatments to our patients.

Emotional Support
While the physical struggle in the fight against cancer is not easy, the emotional struggle can be equally challenging. All cancer patients have access to clinical social workers for complete psychosocial assessment of physical, psychological, social, spiritual, financial, survivorship and resource needs. Clinical social work services are also available to support patient caregivers and families. With the addition of an oncology nurse navigator in the outpatient infusion unit along with the breast navigator, there are systems that have been created to ensure that patient’s needs do not “fall through the cracks.” Navigation has allowed for a closer relationship with the American Cancer Society and the ability to look at the potential barriers to care within our community.

Complete Care, Close to Home
The cancer program at Kent Hospital with the facilities and treatment you need are conveniently located in central Rhode Island allowing patients, families and friends to remain close, which is important during treatment.

Care, Compassion and Hope are more than just words, they are the foundation of our program. With the proper resources, including a dedicated medical staff, state of the art
treatment and caring support close to home, the Cancer Program at Kent Hospital has everything you and your family need.

**Cancer Committee Membership**

Jim Beardsworth, MA, Public Relations and Marketing

Micah Brown-McArthur, RN, Nurse Navigator

Joanne Carlson, RN, Outpatient Infusion

Angela DeRobertis, MD, Radiation Oncology

Candace Dyer, MD, Breast Health Center

Maureen Casey, MBA, RN, CPHQm Quality Improvement

Kathryn Finn, Oncology Social Work

Alexandra Fiore, American Cancer Society

Ellen Healy, MA, LMHC, Oncology Social Work

Pam Hill, RD, Nutrition

John Isaac, MD, Cancer Liaison Physician

Ann Lagasse, CTR, Cancer Registry

Kate Lally, MD, Palliative Care

Naveh Levy, MD, Diagnostic Imaging

Kim McDonough, RN, Breast Health Center

Laurie Miller Jenkins, CTR Cancer Registry/Research Office

Linda Millerick, Cancer Registry/Research Office

Kriti Mittal, MD, Medical Oncology

Patricia Racioppi, RPh, Pharmacy

Naveed Rana, MD, Medical Oncology

Laurie Reeder, MD Thoracic Surgery
2015 Cancer Management Conferences

Kent Hospital is approved by the American College of Surgeons, Commission on Cancer as a Comprehensive Community Hospital Cancer Program.

One of the ways in which we can insure quality of cancer care is by conducting weekly cancer conferences. All specialties are present to discuss the various aspects of cancer patient’s care including Diagnostic Radiology, Radiation Oncology, Medical Oncology, Surgery and other Allied Health Professionals.

Case presentations cover all major cancer sites seen at Kent Hospital. Presenting physicians discuss the patient’s current findings, and past medical history. Radiological studies that have been done are presented to the group by the attending radiologist. Findings are reviewed as well as discussion as to types of additional studies that may be done to help with the diagnosis and/or treatment planning process. Pathology is presented to the team, including current as well as past malignancies if applicable.

Physicians from all disciplines are encouraged to present cases at these conferences. Discussion includes AJCC staging information, treatment plans, clinical trial eligibility as well as follow up care.

General case conferences are held on Wednesdays at 7:30 a.m. in the Kent Hospital Doctors’ Auditorium and the Breast Health Center Tumor Board is held every Friday at 7:30 a.m. in the Breast Health Center Conference Room. A schedule of meetings is posted outside of the doctors cloak room.

Cancer Management Conferences are awarded 1.0 hours in category 1 credits towards the AMA Physician’s Recognition Award.

Please contact the Cancer Registry at extension 31864 if you would like to present a case at this conference.
2015 Kent Hospital Tumor Board Conferences

100% Cases Were Prospective In 2015
Total Meetings Held: 93

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Clinical Trials

Clinical trials are available to all patients with a diagnosis of cancer depending on eligibility. The Cancer program participates in clinical trials as an affiliate member of NRG Oncology through Woman & Infants Hospital, as a parent member. This affiliation gives us access to a variety of oncology trials offered through the Cancer Trials Support Unit (CTSU). Through this site many trials are available to our patients. These include Breast Cancer, Gastrointestinal Cancers, Genitourinary Cancers, Gynecological Cancers, Head and Neck Cancers, Leukemia, Lung Cancer, Lymphoma, Melanoma, Myeloma and Metastatic Cancers.

The following is a list of the clinical research trials currently open to enrollment. If you need any information regarding these trials, or other trials that may be available, please contact Jane White at 401-737-7010 extension 31503.

Breast Cancer

**ALTERNATE:** Alternate Approaches for Clinical Stage II or III Estrogen Receptor Positive Breast Cancer Neoadjuvant Treatment in Postmenopausal Women: A Phase III Study

**Survey Study:** Sexual Function, Desire for Partner Satisfaction and Surgical Decision Making in the Surgical Management of Breast Cancer
Skin Cancer Screening – The skin cancer prevention and screening program was held on Thursday, May 21, 2015 and was well received by everyone. Dr. Frankel, Dr. Bharier and their assistants participated in the event. Fifty-one people were confirmed and 29 attended. There were 11 patients referred for follow-up.

Breast Health Screening – The Breast Screening Program took place on October 27th. There were 7 patients who received a mammogram and a clinical exam. Four patients were recommended for a 6 month follow-up. One patient was recommended for a follow-up with a general surgeon. It was felt that there was a decline of patients this year due to more women having insurance per The Rhode Island Department of Health.
Lung Cancer Prevention and Early Detection Program—A low-dose CAT scan, a lower radiation imaging scan, which can be helpful in finding small, abnormal lung nodules, may be offered to patients based on their risk factors and primary care physicians’ input. Medicare now covers the screenings for at-risk beneficiaries. Doctors from Kent’s multidisciplinary team will provide consult and additional referrals based on testing outcomes. Posters, brochures and scripts have been distributed to physicians.

Support Groups, Resources and Special Events

ACS, Look Good...Feel Better Program—Four workshops were held during 2015. Thirty-two women came to the event.

Kent Hospital Breast Cancer Support Group – The Breast Cancer Support Group meets the 2nd Thursday of each month. There were 16 – 18 participants at each event and all attendees are pleased with the program.
Cruising to Survivorship – The Breast Health Center at Kent’s 6th Annual Health Fair was held May 20, 2015, at the Crowne Plaza Hotel, Warwick, RI. Candace Dyer, MD, physician director of the Breast Health Center moderated the lunch and speaking program. All breast and gynecologic oncology patients and their families were invited. Cancer survivors shared their stories of survivorship. There were about 200 people in attendance.

Annual Breast Health Center fundraiser – the annual fundraiser for the Breast Health Center at Kent’s Women in Need program was held on October 5, 2015. Approximately 200 people attended the event.

Annual Educational Conference sponsored by the Cancer Committee – The event was held on November 4, 2015. Speakers were Kriti Mittal, MD, Updates in Medical Oncology, and Laurie Reeder, MD, Lung Cancer Screening. Twenty physicians and allied health professionals were in attendance.

For more information on these or other programs and services, please call the Cancer Registry at 401-737-7010, extension 31864.
Clinical Studies

Comparison of Robotic and Open Urologic Cancer Surgery

John Isaac, MD, Surgery
Kent Hospital

With the recent acquisition of a DaVinci surgical robot at Kent, the Cancer Committee felt that it would be appropriate to report on a comparison between this new modality and conventional open surgery for cancer. The largest initial experience has been with urologic surgery and this is what will be reported here. We will examine both our experience with prostatectomy and with nephrectomy. This report will document what has been done at Kent. No attempt will be made to compare these results to what has been seen in other institutions. For the most part there are no national standards available that would be universally agreed upon for comparison. Also this report will simply report on the data without recommending one approach over the other. As is always the case the approach to an individual patient should be determined by the individual patient and disease characteristics and should be agreed upon by the treating physician and the patient.

Prostatectomy

Between May 23, 2013, and December 22, 2014, thirty two prostatectomies were done at Kent. These were equally divided between open and robotic cases.

The postoperative length of stay of the patients undergoing a robotic prostatectomy ranged between one and four days with an average length of stay of 1.75 days. The patients undergoing a conventional open prostatectomy were in the hospital from 2 to 7 days after surgery with an average of 3.5 days.

The intraoperative estimated blood loss during a robotic prostatectomy ranged between 25 and 300 cc with an average of 157.8 cc. The blood loss during an open prostatectomy ranged between 100 and 1600 cc with an average of 625 cc. Two of the patients undergoing an open procedure required an intraoperative transfusion while none was required during the robotic procedures.

All of these procedures were done for cancer. A positive surgical margin was reported by the pathology department in four of the sixteen robotic cases (0.25) and six of the sixteen open cases (0.375).

A number of postoperative complications were noted in each group.
Robotic Complications
Post op ileus in 2 patients
Prolonged intubation (24 hr)
Postoperative bleeding (hemoglobin drop from 15.4 to 7.7)
Urinary retention requiring a foley catheter

Open surgical complications
Pulmonary embolus
Delirium Tremens
Post op ileus
Clot retention in 2 patients (1 required 4 readmissions)
Bladder neck contractures in 2 patients requiring TUR within three months

Nephrectomy

Between August 20, 2013 and December 16, 2014 thirty-one nephrectomies were done at Kent, all for malignant disease. There were 21 robotic nephrectomies done. Of these, eleven were total nephrectomies and ten were partial nephrectomies. During this time period there were ten open nephrectomies done. Eight were total nephrectomies and two were partial. Two of these patients had additional procedures performed. One had a colectomy and oophorectomy and another underwent a transanal excision of a rectal tumor.

The postoperative length of stay after a robotic nephrectomy ranged between 2 and 31 days. Not counting the single outlier, the remaining patients were in the hospital from 2 – 6 days. The average length of stay of the entire group was 4.05 days and this dropped to 2.7 days when the outlier was not included. In the open group, the length of stay ranged between 3 and 11 days with an average of 5.3 days.

The estimated blood loss for the robotic group ranged between five and 800 cc with an average of 154.7 cc. In the open group the range was between 200 cc and 2500 cc with an average of 1245 cc.

Positive pathologic margins were reported in 4 of the 21 robotic cases (0.19) with an additional patient having a margin of less than 0.1 mm. Positive margins were noted in three of the ten open cases (0.3).

Robotic complications
Ileus – 2 patients, one required readmission
Post op CVA (31 day LOS)
Post op hand numbness
Post op hand weakness
Prolonged intubation

Open Complications
Pneumonia
Intraoperative kidney fracture with possible tumor spillage
**Hereditary Breast Cancer and Genetics**  
*The Breast Health Center at Kent*

**Candace Dyer, MD, Surgery**

The purpose of this study was to assess whether patients referred for genetic evaluation went, and if not, why. In addition, we wanted to see if we were referring and testing an appropriate number of our patients and whether results affected patients’ decisions.

Breast Cancer affects approximately 11-12% of women in the United States and the incidence in RI is a bit higher, for unclear reasons. Most of these are familial or sporadic, meaning there are currently no known causes.

Approximately 5-10% of these breast cancers will be inherited, which means a genetic mutation that predisposes one to breast cancer may be passed down from one parent to an offspring.

The majority of hereditary breast cancers are related to BRCA 1 and BRCA 2 genes which are autosomal dominant genes. This means they can be transmitted from either parent and there is a 50/50 chance an offspring will inherit the gene.

Everyone has BRCA 1 and BRCA 2 genes. They have an important function in repairing cell damage and, thus, keep cells healthy. However, if there is a mutation or abnormality with one of the genes, cells can multiply and become cancerous.

Female BRCA 1 or BRCA 2 carriers have an increased lifetime risk of getting not only breast cancer (50-80%) but ovarian cancer (10-40%).

Prophylactic oophorectomy after child bearing age can reduce the risk of ovarian cancer by 90% and breast cancer by 50%. Risk reduction medications like tamoxifen can also reduce the risk of breast cancer by 50%. Prophylactic mastectomies reduce the risk by over 90%.
There are other genes that increase the risk for breast cancer that may also be inherited, though these are less frequent. These include: ATM, p53, CHEK2, PTEN, CDH1, PALB2, RINT1, MRE11A, RAD50, NBN and possibly others.

The decision as to which patients should undergo testing and which genes should be tested, in our opinion, should be a joint one, in consultation with a genetic counselor, the patient and her/his physician. There are ramifications of testing that patients need to be aware of, such as the realization of an increased risk for not only the patient but her offspring, the potential need to undergo more intense screening or radical procedures to reduce the risk of developing a cancer, or recurrence, and the potential for insurance discrimination. It is against the law for health insurers to discriminate but not for other insurers, specifically companies that provide life insurance.

A genetic counselor is trained and prepared to discuss not only the patient’s overall risk, but which genes should be tested, based on these risks, as well as the consequences of testing. They also provide recommendations in the event a test is positive.

At the BHC at Kent, an affiliate of the W&I BHC, we try to identify patients who should undergo genetic counseling. For patients affected with breast cancer, we now discuss genetic referrals at our joint tumor board. Patients with high risk lesions are also identified, though not all of these patients end up being presented at TB.

Unaffected patients, those without a personal history of cancer, or a biopsy proven high risk lesion, are often referred to the BHC for a consultation regarding their risk. Careful personal and family history is taken and risk assessment using the Gail Model is performed to help the physicians identify potential patients that might benefit from genetic evaluation or additional screening tests. This is the most commonly used model in the USA and takes into account some personal characteristics of the patient as well as history of breast and ovarian cancer in first degree relatives. This model probably misses some high risk patients so the physician may request a genetic referral even if the Gail Model score is lower than expected.

The American Society of Breast Surgeons’ web site has a Mastery of Surgery Link that also can calculate an individual patient’s risk, not only using the Gail model but the Tyrer Cuzick and BRCAPRO models. While these models are not used to guide genetic testing by our geneticists, they are helpful in assessing overall risk.

The geneticists follow NCCN guidelines. The specific criteria include:
- Early age breast cancer, less than 50.
- Second breast cancer.
- Family history of multiple members with breast and/or ovarian cancer, especially if onset was under age 50.
- Family history of both breast and ovarian cancers.
- Family history of specific other malignancies, such as thyroid, pancreatic and colon.  
- Family history of male breast cancer.  
- Triple negative breast cancers.  
- Ashkenazi Jewish heritage. Other ethnic groups have an increased risk but since we do not encounter these folks here frequently we do not specifically inquire about these groups; Dutch, Icelandic and Norwegian, though our counselors do.  
- African American heritage if breast cancer occurs under age 35.

We rely on the consulting physician to identify non affected patients at risk but, unfortunately, we do not have a mechanism in place to track these individuals, though we are now trying to keep a list of these individuals.

According to the genetic counselor, there is a CPT code (96040) for counseling and the charge is $150/30 minutes, though this may vary depending on the contractual agreement between the hospital and the third party payer.

The first appointment generally takes 90 minutes. It is usually at this meeting that the decision to proceed with testing is made. There is usually a follow-up appointment to discuss the results and all patients are advised to attend this appointment, even if the test results are negative as there may still be significant risk and, perhaps other testing will be recommended.

Most insurers in RI currently do reimburse for counseling, though this was not the case back in 2010. Non-commercial Medicare, State Medicaid and Rite Care do not reimburse for these services.

Once testing has been recommended, prior approval is required for the actual test and many times the testing may be denied. Or, if approved and performed but additional testing is recommended, these are frequently denied.

The test(s) is performed at outside labs and the cost may differ, especially now that additional panel testing is offered.

I have not delved into these cases that have been denied but it worries me that state/federal insurance plans do not cover these services. Thus, access to this important part of cancer care is limited for these individuals.

PATIENTS AFFECTED WITH BREAST CANCER, DIAGNOSED AND TREATED AT KENT

We looked at all of our cancer patients that have been seen at the BHC at Kent from January 1, 2010 to August 31, 2015. There were approximately 3000 new patients seen in the BHC during this time period. Of these, 544 have been diagnosed with and/or treated at our facility for breast cancer.
Tumor board records were reviewed and recommendations from treating physicians were reviewed and were documented in a log. Patients deciding to undergo counseling were then further reviewed to see if they actually underwent testing, what the results were and whether these results affected their decision regarding treatment.

Of the total number of breast cancer patients treated at our center:

143 were offered genetic counseling.
81 saw the counselor.
62 did not. One of these patient’s mother had been tested and was negative.
One patient’s daughter had been tested and was negative.
It is unclear why the remaining 60 patients did not appear for counseling.
Some declined, some were no shows at appointments and some never responded to our inquiries. Generally, when we did get an answer it was usually due to out of pocket expenses which they felt they could not afford.
The counselor felt one patient did not need testing.

76 patients underwent BRCA testing.
8 tests were positive; 4 for BRCA 2 and 3 for BRCA 1 and 1 for an MRE11a mutation of unknown significance.

One patient who tested negative had a daughter that was BRCA 2+, from her paternal side.
6 BRCA negative patients also underwent additional BART analysis and all tested negative, though one was found to have possible Lynch Syndrome and one is still pending.

NON AFFECTED PATIENTS AT INCREASED RISK

Charts of patients who presented to the BHC without a diagnosis of breast cancer but deemed at increased risk for developing the disease were reviewed during this time frame.

133 patients were identified as having a significant risk to warrant genetic evaluation.

These patients ranged in age between 23-73 years of age and 12 of these were 35 years or younger. Risk assessment using the Gail Model was performed for all patients over age 35 years old.
Risk, according to this model, ranged from 7.1 – 38.1% for life time risk.

6 patients had a high risk lesion themselves.
2 had Ashkenazi Jewish heritage; one had a brother that tested positive for BRCA 2.
All 133 patients were advised to see a genetic counselor.

61 did not go for counseling. Records indicate 10 of these decided not to go because they were denied coverage and could not afford the out of pocket expenses or they did not want to know.

One patient declined because she had already undergone testing through her GYN’s office. The test reportedly was negative. Another had a sister that had tested negative for both BRCA 1 and 2.

Why the additional 50 patients did not go is unclear. Of the remaining patients, 72, or 54% saw the genetic counselor and testing was not recommended in 6 of these. 3 were not deemed to be at high enough risk to warrant testing and the geneticist advised affected family members of the other 3 be tested. 2 complied and both tested negative.

66 patients underwent genetic testing.
3 tested positive for BRCA 2 (ages 26, 47, and 63).
1 tested positive for BRCA 1 (age 42).
1 tested positive for RAD 50+ (age 42).
1 tested positive for APC gene (age 31).

6/66 or 9.09% had a positive test for some sort of mutation.

Targeted testing for BRCA 2 only was performed in 3 patients and all three tested negative.
Targeted testing for p53 was carried out in 1 patient who also tested negative.

All of these patients decided to manage their positive results with increased surveillance.

Of the few patients that were found to have a genetic mutation, their risk for developing breast cancer, according to the Gail Model, was 16 – 19%.
2 patients were too young for a Gail Model assessment.

An unclear number of negatively tested patients were offered additional testing but declined because of cost.
One had BreastNext Testing, which included several additional genes besides BRCA 1 and 2 and tested negative for this as well.
There are still a few (8) where testing is pending.

One patient with BRCA 2 decided to undergo bilateral skin sparing mastectomies (SSM) with reconstruction and BSO.
Another patient with BRCA 1 has just completed her neoadjuvant chemotherapy and is planning on bilateral skin sparing mastectomies and BSO.

The patient with Lynch Syndrome has had a negative BBCA 1 and 2 and negative BART but her insurance company has denied further testing to date, so Lynch Syndrome has not been verified, though family history of colon cancer at a young age raises this possibility. It was suggested that this affected patient undergo testing, but we do not have any follow up on this.

BREAST/OVARIAN CANCER PATIENTS DIAGNOSED AND TREATED ELSEWHERE

In addition to the patients discussed above, six additional patients with a remote personal history of breast/ovarian cancer came to the BHC to assess their overall risk of a genetic predisposition and all six were referred.

One patient had a history of bilateral breast cancers, had previously undergone bilateral mastectomies and had a prior history of THA/BSO. She tested positive for BRCA 2 and it was recommended her children be tested.

Three patients had unilateral IDC and tested negative.

One patient had DCIS and tested negative.

One patient with a remote history of ovarian cancer, tested positive for BRCA 1 and currently has decided to increase surveillance for breast cancer.

SUMMARY OF FINDINGS

In summary, there 544 patients diagnosed and/or treated for breast cancer at Kent during the time frame noted above and 6 additional patients with a remote history of breast/ovarian cancer that were seen at the BHC.

While many more non affected patients were evaluated for benign disease, 133 of these were felt to have increased risk.

A total # 282 patients were offered counseling.
# 142 underwent testing.
# 7 tested positive for BRCA 2.
# 4 tested positive for BRCA 1.
# 1 tested positive for Lynch Syndrome.
# 1 tested positive for RAD 50.
# 1 tested positive for APC.
# 1 tested positive for a significant gene MRE11A.
# is pending.
15 positive patients out of a total of 142 tested gives a positivity rate of approximately 10.5% which is about the national average for the incidence for hereditary breast cancer and/or genetic predisposition.

Unfortunately, 139 patients who could have benefited from genetic evaluation did not pursue it for a variety of reasons, though we do not have a very good understanding of the reasons why they did not at least see a geneticist. Our hope was to send a questionnaire to these patients to clarify this but there were some concerns regarding sending this. Perhaps this could be re-visited as it is difficult to remedy a problem without knowing what the real issues are.

The one thing we want to be certain of is that providers are making these recommendations. However, time restraints on providers may limit their ability to spend a lot of time discussing this, especially in patients diagnosed with breast cancer, who are undergoing discussion regarding treatment and prognosis and who are already overwhelmed. When the BHC at Kent opened, genetics was not a consistent topic brought up at Tumor Board. But that has changed and this can aid providers with their discussions with patients. The TB recommendations also go to other treating physicians so, hopefully, these recommendations can provide additional impetus for discussion by primary care physicians.

At the BHC there is a definite need to add personnel, such as an RNP, who could address this issue as well as many others.

The other major issue relates to coverage and payment for these services. There are discrepancies in coverage that affect access to this valuable service. Fortunately most insurers are now following NCCN guidelines and are covering this service, at least for the basic BRCA 1 and 2 tests. But there is still a significant rate of denial for advanced testing. We should strive to change this.

From the preliminary data it appears patients with state funded insurance plans are less likely to benefit from these services, and thus, are somewhat discriminated against. Clearly, this is not right! We definitely must seek ways to assure ALL patients, regardless of their coverage, have the same access to this important service.

If out of pocket expenses is a major problem for some patients we could possibly provide some aid from our Women In Need program funds (WIN) or look into other options.

Although we looked at the Gail Model to assess risk, it has limitations since only first degree relatives are considered. The % given a specific patient really did not reflect in the overall positivity rate. The literature has looked at other models but there remain limitations, as most of these models incorporate only breast and ovarian cancer and do
not consider other malignancies in the family that may also carry significant risk for the individual patient. This is why it is so important to have patients evaluated by a genetic counselor rather than just advising testing or foregoing testing if the risk seems low based on the models currently used.

The Gail Model, as well as the others utilized by the ASBS and other organizations, is more helpful in deciding which individuals would benefit from additional screening tests, such as US and/or MRI, and often the third party payers will not cover these additional tests, especially MRI due to their high costs, unless the lifetime risk is over 20%.

Decision making as a result of a positive test was dependent on the age of the patients, and whether she was already affected with breast cancer.

This process was very time consuming and tedious and most likely did not capture all patients. We need a better way to do this.

ADDENDUM

A survey was sent to patients regarding factors preventing them from undergoing genetic counseling and/or testing. The main issue for patients was financial and non-coverage by insurers and potential out of pocket expenses.

We, therefore, decided to refer patients to our Financial Service Department. However, during the last three months, from May 1, 2016 – August 31, 2016, 25 patients were referred and only 4 required financial assistance. These four received assistance through the Alves Fund.

I have discussed financial issues with one of the geneticists and she indicated most insurance companies are now covering this essential service so; hopefully going forward it will become a non-issue.

Review of Cases from the Top Five Cancer Sites
Kent Hospital, Warwick, RI
Primary Reviewer: Bachir Sakr, MD, Hematology/Oncology

The purpose of this chart review is to assess whether patients within the cancer program at Kent Hospital are evaluated and treated according to national treatment guidelines.
Fifty-two patient charts (10%) were randomly selected for review from the 531 analytic cases in the tumor registry abstracted in the last twelve months. In each case, the following data points were obtained from the electronic record and/or tumor registry: age, tumor primary origin, date of initial diagnosis, tumor stage, other tumor characteristics when pertinent (such as grade, receptor status, number of lymph nodes removed, margin status...), date of first treatment, type of first treatment and additional treatments.

This information is presented in five tables each representing one of the main tumor sites: breast, lung, colorectal, prostate and bladder.

**Bladder Cancer** - Eight patients with bladder cancer were included in this review:

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<td>3</td>
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<td>Clear</td>
<td>TURBT. F/up not on record</td>
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</table>

- Two patients had low grade, non-invasive papillary carcinoma (Stage 0A) both of whom underwent excisional biopsy without further surgical intervention. There was no record of the type of follow-up they received. In both cases treatment was consistent with NCCN guidelines.

- Two patients had high grade, non-muscle invasive carcinoma (Stage I) and underwent TURBT with clear margins as first course of treatment. This is consistent with NCCN guidelines.
One patient had high grade, non-muscle invasive carcinoma (Stage I) and excisional biopsy with tumor fulguration as primary treatment. The patient did not undergo TURBT. This is NOT consistent with NCCN guidelines but is reasonable treatment considering the patient’s age and comorbidities.

Two patients presented with muscle invasive disease (CT2N0) and proceeded directly to radical cystectomy. NCCN guidelines favor the use of neoadjuvant chemotherapy prior to cystectomy.

One patient presented with muscle invasive disease, was deemed medically inoperable and was treated with TURBT.

**Prostate Cancer** – Seven patients with prostate cancer were included in this study:

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Five patients underwent radical prostatectomy as their first treatment, consistent with NCCN guidelines.

One patient was treated with TURP only, due to severe co-morbidities.

One patient with clinical Stage T2c disease refused definitive therapy and received androgen deprivation therapy.
Colon Cancer – Eight patients with colon cancer were included in this study.

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- Six patients with resectable disease underwent the recommended surgical procedure consistent with NCCN guidelines.
- The remaining two patients presented with metastatic disease and received supportive care only.

Lung Cancer – Eleven patients with lung cancer were included in this study.

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<td>Medically inoperable. Poor PFT; Pancoast tumor; weekly taxol/carbo +XRT</td>
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</table>
---|---|---|---|---
2/10/2014 | 3B – T3N2 | 3/25/2014 | XRT, chemotherapy with carbo/taxol
4/10/2014 | 1B – T2aN0 | 5/09/2014 | 26 | VATS lobectomy and lymph node sampling. No chemotherapy.
4/04/2013 | 2A – cT3N0 | | | Medically inoperable. Chemo-radiation started within weeks of diagnosis, then diagnosed with metastatic disease.
8/26/2015 | 4 | | | None. Hospice care. Died within a few weeks of diagnosis.
3/19/2014 | 4 | | | Probable diagnosis of lung cancer. No biopsy/tissue. Received hospice care.

- Four patients presented with Stage IV disease and went on to receive either first line platinum based chemotherapy consistent with NCCN guidelines or supportive care.
- Three patients with Stage IA – IB disease underwent lobectomy and lymph node dissection, treatment consistent with NCCN guidelines.
- One patient with Stage IIA disease was deemed medically inoperable and was treated with chemoradiotherapy, consistent with NCCN guidelines.
- One patient with Stage IIB disease and limited lung function underwent wedge resection and lymph node sampling, consistent with NCCN guidelines.
- One patient with Stage IIIA disease deemed medical inoperable was treated with chemoradiotherapy, consistent with NCCN guidelines.

**Breast Cancer** – Eighteen patients with breast cancer were included in this study:

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</table>
- All invasive tumors were tested for the ER, PR and HER2 and all DCIS were tested for ER.

- Three patients with DCIS were treated with either lumpectomy or mastectomy. One patient with lumpectomy received radiation therapy and the other chose not to receive radiation. This is consistent with NCCN guidelines.

- Nine patients with invasive disease received primary surgery with partial mastectomy or mastectomy with either sentinel node biopsy or axillary dissection as per NCCN guidelines.
Six patients received neoadjuvant systemic therapy followed by surgery. This is also consistent with NCCN guidelines.

Seven patients treated with partial mastectomy went on to receive adjuvant radiation therapy as per NCCN guidelines.

Three patients age seventy or older, with hormone receptor positive disease that were treated with partial mastectomy did not receive adjuvant radiation therapy but did receive adjuvant endocrine therapy. This is consistent with national guidelines.

One 93 year old patient received no therapy beyond partial mastectomy due to age and co-morbidities.

**Percentage of New Cases Compared to National And State Estimates**

*Estimated Data from ACS Fact and Figures 2015*
## 2015 Kent Hospital Accessions

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The Kent Hospital Cancer Registry staff would like to thank
the physicians and their office staff for providing us with vital information
regarding treatment and follow-up on their patients.