



**Edwards**  
Comprehensive  
Cancer Center



# Oncology Committee

ANNUAL REPORT 2012

**Cabell**Huntington Hospital



## ONCOLOGY COMMITTEE — 2012 – 2013

### MANDATORY REPRESENTATION - PHYSICIANS

CHAIRMAN  
ACoS LIAISON PHYSICIAN  
SURGERY

MEDICAL ONCOLOGY

DIAGNOSTIC RADIOLOGY  
RADIATION ONCOLOGY  
PATHOLOGY

G. Oakley, MD, Gynecology Oncology  
Maria Tirona, MD, Medical Oncology  
Jack Traylor, MD  
Shawn McKinney, MD  
A. Chowdhary, MD  
R. Sehgal, MD  
M. Khasawneh, MD  
P. Chirico, MD  
A. Freeman, MD  
Linda Brown, MD  
D. Griswold, MD  
J. Oakley, MD, Molecular Pathology

### MANDATORY REPRESENTATION – NON-PHYSICIANS:

CANCER PROGRAM ADMINISTRATOR  
ADMINISTRATION  
CANCER REGISTRY

ONCOLOGY NURSING

SOCIAL SERVICES  
QUALITY ASSURANCE

CLINICAL RESEARCH ASSOCIATE

PALLIATIVE CARE SPECIALIST

Chad Schaeffer, FACHE, Executive Director ECCC  
Hoyt Burdick, MD, VP Medical Affairs  
Phyllis Edwards, RHIT, CTR, CCS –  
*Cancer Registry Quality Coordinator*  
Shelby Moore, CTR, CCS –  
*Cancer Conference Coordinator*  
Molly Sarver, RN, OCN  
Kim Seeber, RN, OCN  
Mary Beth Hager, BSW  
Margaret Wagnerowski, RN, MSN, AOCN, AOCNS-  
Quality Improvement Coordinator  
Leann Ross, RN, OCN, CCRP-  
Clinical Research Coordinator  
C. McCormick, MD  
Sheila Stephens, DNP, MBA, AOCN-  
*Interim Psychosocial Services Coordinator*

### ADDITIONAL SPECIALTY MEMBERS

#### *Specialty Physician Members:*

SURGICAL ONCOLOGY  
GYN ONCOLOGY  
UROLOGY  
ORTHOPEDIC ONCOLOGY  
PULMONARY  
PEDIATRIC ONCOLOGY  
THORACIC SURGERY

Wade Douglas, MD  
Gerard Oakley, MD, Chairman  
James Jensen, MD  
F. Cheung, MD  
A. Lorenzana, MD  
M. Mogul, MD  
J. Kiev, MD

#### *Specialty Non-Physician Members:*

PHARMACY  
HOME HEALTH  
CLINICAL TRIALS NURSE  
COMMUNITY OUTREACH COORDINATOR  
AMERICAN CANCER SOCIETY

Chris Larck, PharmD  
Andra Hardin, RN, Dir. Home Health  
Teresa Giles, RN  
GiGi Gerlach, RN, OCN  
Michelle Chappell, State Mission Delivery Director  
Terri Francis  
Angie Hayes, MS, CMD  
Lisa Muto, MSN, WHNP-BC, OCN  
Julie Morrison, MA  
Marsha Dillow, RN, MSN

ECCC RADIATION ONCOLOGY  
GENETIC COUNSELING  
TISSUE PROCUREMENT  
BREAST CENTER  
PSYCHOLOGY  
REHAB REPRESENTATIVE  
LYMPHEDEMA PROGRAM  
SITE NAVIGATORS:

Molly O'Dell, OTR/L, CDT  
Heather Streets, RN, MDC LUNG NAVIGATOR  
Jennifer Brown, RN, COLORECTAL NAVIGATOR  
Susan Hale  
Caroline Schlatt, Program Development Coordinator

NUTRITIONIST  
WV COMPREHENSIVE CANCER PLAN



**2012 ANNUAL REPORT**  
EDWARDS COMPREHENSIVE CANCER CENTER



*Shawn McKinney, MD, surgical breast oncologist, is the only surgeon in the Tri-State to have completed a fellowship in Breast Oncology after completing her General Surgery Residency. Her additional years of in-depth training in the treatment of breast cancer at Baylor Medical Center provide patients at the ECCC the best care possible.*

**I**n the last year, the Breast Program at the Edwards Comprehensive Cancer Center (ECCC) voluntarily underwent a rigorous review process and earned accreditation from the National Accreditation Program for Breast Centers (NAPBC), a national consortium of professional organizations dedicated to the improvement of the quality of care and outcomes for patients with breast diseases. In addition, the program has also been named a Breast Imaging Center of Excellence by the American College of Radiology.

In the following pages you will find that the ECCC takes to heart the charge made by the American College of Surgeon's Commission on Cancer to ensure that "patients with cancer will receive the highest quality care close to home." This annual report will provide details on patient and program outcomes, focusing on breast cancer.

#### Standard 4.1 Prevention Programs

ECCC meets this standard through the high-risk breast cancer program. Lisa Muto, DNP, WHNP-BC, APNG, OCN® provides genetic testing and care for women at high risk to develop breast cancer. ECCC is the only facility in the state and the region to have an advanced practice nurse in genetics on staff. A full description of this program is available in the pages to follow.

#### Standard 4.2 Screening Programs

The ECCC provides annual cancer screening programs, including a breast cancer screening that offers clinical breast exams. The ECCC has been able to provide mammography for uninsured and underinsured women through partnerships with the Ebenezer Medical Outreach, the West Virginia Breast and Cervical Screening Program, previous grants from the WV affiliation of the Susan G. Komen Foundation and donations from the ECCC Benevolent Fund. In 2012, free clinical breast exams were provided for 74 women during the annual breast screening, and 34 women were referred for mammography as a result of this screening.

It is important that women attending free screenings receive the necessary follow-up care, should it be required. Representatives from the Ebenezer Medical Outreach and the West Virginia Breast and Cervical Screening Program are available at the free screenings to meet women eligible for these programs. This collaboration ensures that costs for further testing or treatment are covered.

#### Standard 4.4 Accountability Measures

The ECCC has determined that the guidelines from the National Comprehensive Cancer Network (NCCN) will be the standard of care for all cancer-related care provided at the Cancer Center. These guidelines are discussed weekly in Tumor Board. The Breast Program provides ongoing measures to identify potential problems and areas for improvement. Cancer Program Practice Profile Reports (CP3R) are measures designed to improve the quality of patient care by benchmarking ECCC

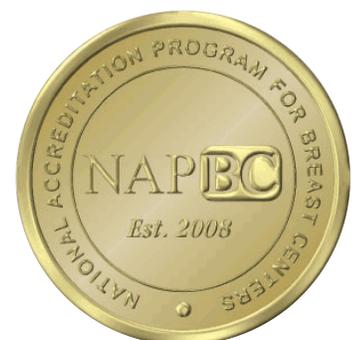
outcomes against outcomes of other CoC facilities. The ECCC Cancer Committee reviews all CP3R reports and addresses performance at committee meetings, as does the Breast Leadership Committee.

#### Standard 4.6 Monitoring Compliance with Evidence-Based Guidelines

This report will provide an in-depth evaluation of the breast program, as required by this standard. The performance measures for NAPBC standards will be compared with the NCCN guidelines. These include breast conservative surgery for women with Stage 0, I or II; needle/core biopsy prior to surgical treatment of breast cancer; radiation therapy for conserving surgery; radiation for mastectomy patients with four or more positive nodes; chemotherapy for women with Stage I, II, or III hormone receptor negative disease; and use of tamoxifen or an AI for Stage I, II or III hormone receptor positive breast cancer.

#### Standard 4.7 Studies of Quality

In addition, Studies of Quality were completed in 2011. As a certified participant in the National Quality Measures for Breast Centers® (NQMBC®), the ECCC has established benchmarks for active monitoring of services and outcomes to provide our patients with the highest quality of care. The ECCC is also awaiting the benchmark data from the ONS Pilot Study, Breast Cancer Survivorship Quality Measures. All data has been submitted, and an audit of data has been conducted by ONS and JCAHO. Further, data is also benchmarked with the American Society of Breast Surgeons Mastery of Breast Surgery Program.



#### **Standard 4.6 – Monitoring Compliance with Evidence-Based Guidelines**

According to the Commission on Cancer standards for accredited cancer programs, a physician member of the Cancer Committee will assess compliance with evidence-based national guidelines for the treatment and evaluation of patients at Cabell Huntington Hospital or the Edwards Comprehensive Cancer Center (ECCC). In addition to these standards, the Breast Leadership Program also reviews the performance measures annually for the American College of Surgeons' National Accreditation Program for Breast Centers (NAPBC).

As the Chair of the Breast Leadership Program, Shawn McKinney, M.D., reviewed the NAPBC performance standards using the data from the Cancer Registry. The data was then compared with national guidelines. The National Comprehensive Cancer Network (NCCN) guidelines provide the standard of care for all patients evaluated and treated at the ECCC. The following performance measures have been reviewed and compared to the NCCN Breast Cancer guidelines, version 3.2012 unless otherwise noted (available at [www.nccn.org](http://www.nccn.org)).

The review included all women diagnosed with breast cancer at this facility in 2011. While there were 131 total cases, only 99 of these women were diagnosed and treated at this facility.

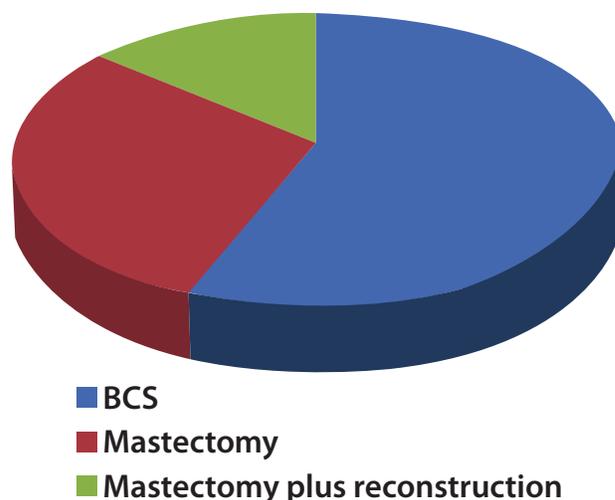
#### **Breast conservative surgery rate for women with AJCC Stage 0, I, or II breast cancer.**

The NCCN guidelines describe either lumpectomy with surgical axillary staging or total mastectomy with surgical axillary staging (with or without reconstruction) as a Category 1 recommendation for women with Clinical Stage 1, IIA or IIB disease.

There were 64 patients diagnosed with Stage 0, I, or II breast cancer at the ECCC in 2011. In fact 64% of all breast cancer cases diagnosed were early stage and 100% of these patients received a lumpectomy, mastectomy or mastectomy with reconstruction. All patients

received axillary staging. While breast conserving surgery (BCS) is the optimal choice for most women with early stage disease, the location of the tumor and patient co-morbidities can preclude BCS as a surgical recommendation. In addition, women with breast cancer are given options for treatment and may elect to have a more aggressive surgery even when BCS is the recommendation. At the ECCC, 56% of women with Stage 0, I, or II elected for BCS in 2011. In addition, 32% of the women who chose mastectomy elected to have reconstruction as part of their treatment choice.

#### **Stage 0, I, II Breast Cancer Surgical Treatment**



The NCCN guidelines note that contraindications for BCS include prior radiation to the breast or chest wall; early trimester pregnancy; diffuse suspicious or malignant appearing microcalcifications; widespread disease that cannot be incorporated by local excisions and achieve negative margins with satisfactory cosmetic effect; and positive pathology margin. According to the guidelines, contraindications may also include active connective tissue disease; tumors larger than 5 cm; focally positive margin; and women with known, or suspected, genetic predisposition.

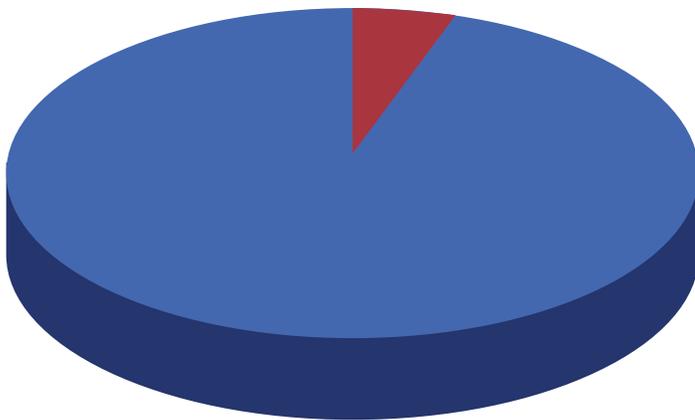
The data from this review conducted of patients at the ECCC were reflective of these contraindications and the data from other studies. In their study, "Surgeon recommendations and receipt of mastectomy for treatment of breast cancer," (JAMA 2009), Morrow,

Jaqui, Alderman, Griggs, et al. noted that breast conserving surgery was recommended by surgeons and attempted in the majority of patients; however surgical recommendation, patient decision and failure of BCS were all factors in contributing to the mastectomy rate.

**Needle/core biopsy is performed prior to surgical treatment of breast cancer.**

In the NCCN guidelines (version 1.2012 for Breast Screening and Diagnosis) there is a Category 2 recommendation for tissue biopsy to be performed by fine needle aspiration or core biopsy (by needle or vacuum). At the ECCO, 95% of all patients receive a needle or core biopsy prior to any surgical treatment. While needle or core biopsy is considered the initial route of biopsy, it can be contraindicated in some patients. Some patients are not able to tolerate the position for the testing and others have tumors located in areas of the breast where needle biopsy or stereotactic procedures cannot be accomplished.

**Needle biopsy prior to surgery**



■ Needle biopsy  
■ Not a candidate

**Radiation therapy is administered within one year of diagnosis for women undergoing a mastectomy for breast cancer with four or more positive regional lymph nodes.**

The NCCN guidelines have issued a Category 1 recommendation that all women with four or more positive lymph nodes should undergo radiation therapy. In 2011 at ECCO, 100% of the women undergoing mastectomy and having four or more positive lymph nodes received

radiation therapy within one year of diagnosis.

**Radiation therapy is administered within one year of diagnosis for women under age 70 receiving BCS for breast cancer.**

The NCCN guidelines have a Category 1 recommendation that all women under the age of 70 who receive BCS should receive radiation therapy following chemotherapy. In 2011 at the ECCO, 100% of the women under the age of 70 and receiving BCS were given radiation within one year of diagnosis. Radiation therapy can be contraindicated in women with certain other co-morbidities or in women who are unable to be positioned on the table.

**Combined chemotherapy is considered or administered within four months (120 days) of diagnosis for women under the age of 70 with AJCC T1c, Stage II or III hormone receptor negative breast cancer.**

The NCCN recommends adjuvant chemotherapy for women hormone receptor negative breast cancer as a Category 1 recommendation. In 2011 at the ECCO, 100% of these women did indeed receive a combined chemotherapy regimen within 120 days of diagnosis.

**Tamoxifen or third generation aromatase inhibitor (AI) is considered or administered within one year (365 days) of diagnosis for women with AJCC T1c, Stage II or II hormone receptor positive breast cancer.**

Tamoxifen or an AI was recommended or administered in 100% of the 39 women who met these criteria. One woman refused the recommendation, resulting in 38 of the 39 women actually receiving the treatment.

Sincerely,

**Shawn McKinney, MD**

**Surgical Breast Oncologist  
Edwards Comprehensive Cancer Center**



### Cancer Prevention

*Lisa Muto,*

*DNP, WHNP-BC, APNG, OCN®*

Because some women with certain risk factors are at increased risk for breast cancer, the Edwards Comprehensive Cancer Center has developed the Breast Cancer Risk Assessment Program to

identify counsel and manage these women. This program consists of cancer experts who provide personalized risk assessment and recommendations for women who are at high risk for breast cancer. Our team includes a board-certified women's health nurse practitioner who is also oncology certified (OCN) and an advanced practice nurse in genetics (APNG) and our fellowship-trained board-certified surgical breast oncologist. Identifying women at increased risk, increasing surveillance and implementing risk reduction strategies can increase early detection, leading to better prognosis and outcomes. Risk factors can include a family history of breast cancer diagnosed before age 50 or male breast cancer at any age, more than two first- or second-degree relatives diagnosed with breast cancer, personal or family history of a known genetic mutation, personal history of LCIS or atypical hyperplasia or personal history of thoracic radiation prior to age 30. Addressing these risks can include increased surveillance, lifestyle modifications, chemoprevention and preventative surgeries.

Our nurse practitioner was the primary investigator on a clinical trial entitled "The Effectiveness of a Nurse-Run Clinic For Women at Increased Risk for Breast Cancer on Anxiety, Depression, and Cancer Worry." The purpose of this project was to evaluate the effect of a nurse-run clinic for women at increased risk for breast cancer on anxiety, depression and cancer worry. The objectives were to tailor the appointment based on the responses of the woman to the Ways of Coping Checklist and to decrease symptoms of anxiety, depression and/or cancer worry in

women who are experiencing anxiety, depression and/or cancer worry. Results were significant for a decrease in anxiety ( $P=0.047$ ). Although mean depression and cancer worry scores decreased from pre-test to post-test, results were non-significant. These results provide information that helps us to offer the best possible care for women at risk for breast cancer.



### Does cancer research really make a difference?

*Leann Ross, BSN, OCN®*

This is a question that may not always be voiced but has undoubtedly crossed the minds of many. Still, too often faced with less than optimal outcomes and statistics, it is easy to succumb to the nagging feeling that cancer is still winning. However, a quick look back is an encouraging reminder of how far cancer care has actually come and how patients' lives have been improved by advances gained through research. Because of evidence and knowledge acquired through research, many cancers are detected earlier, treated more effectively and some are now cured. A quick review of a few of the significant changes in the treatment of breast cancer highlights the impact that research has had on cancer care.

At the turn of the 20th century, radical mastectomy was the standard treatment for breast cancer. Though the surgery mildly improved survival rates and decreased local recurrence, it was disfiguring and associated with significant side effects. In 1932, the modified radical mastectomy (MRM), which spares the pectoralis major (chest wall muscle) was developed. MRM later became the standard of care in early stage breast cancer. In the '30s and '40s, two major breakthroughs occurred: the first chemotherapeutic agent (nitrogen mustard) was discovered and used (this was the forerunner of chemotherapy agents that would be used to treat breast

cancer) and researchers found that certain hormones play a role in the growth of some cancers. In 1958, a randomized clinical trial showed the first evidence that chemotherapy could significantly decrease early recurrence rates.

By the 1960s, suppression of ovarian function and hormone production were linked to improved outcomes for breast cancer patients. Clinical trials conducted in the '70s led to the use of adjuvant (post-op) chemotherapy. In the '80s, research showed lumpectomy and radiation to be as effective as mastectomy for early stage breast cancer, and a clinical trial showed Tamoxifen decreases recurrence and increases survival in women with ER+ node negative tumors. The research focus of the '90s was in the genomics of cancer. The BRCA1 and BRCA2 genes were cloned, and researchers discovered that women who inherit these mutations have increased risk of developing breast cancer. This finding led to chemoprevention trials that confirmed that antiestrogens can reduce the risk of invasive cancer in women at high risk.

Researchers and clinical trials in the 21st century continue to explore cancer at the molecular level, recognizing that breast cancer is a complex disease with several distinct

genetic subtypes. This understanding has taken much of the current cancer research in the direction of genetic profiling of tumors so that interventions can be targeted to the specific tumor type.

From this abbreviated review, it is clear that research does make a difference in the way we treat cancer and how patients are living with cancer. Cancer research is an ongoing process; the very data that answers one question often prompts another. Through collaboration with basic science researchers and participation in nationally sponsored clinical trials, ECCC physicians, researchers and research staff are committed to finding answers that increase the understanding and treatment of cancer. Clinical trials are an important aspect of the care offered to ECCC patients, providing them with valuable treatment options and the opportunity to contribute to the body of knowledge about cancer. There are currently 28 clinical trials open to enrollment; 19 are trials that involve treatment, and the other nine include cancer outcome studies and tissue procurement. In the past 11 months, ECCC has enrolled 160 patients (14 are breast cancer patients) to clinical trials and collected 86 specimens for tissue banking.



**Edwards Comprehensive  
Cancer Center**

1400 Hal Greer Boulevard • Huntington, WV 25701  
[www.edwardsccc.org](http://www.edwardsccc.org)



**Cabell Huntington Hospital**

*Your Partners for Life*





The Edwards Comprehensive Cancer Center (ECCC) at Cabell Huntington Hospital provides treatment of adults and children with cancer. Patients will find a warm, inviting atmosphere and a convenient approach to treatment and testing, with a complete array of services under one roof. Patients can see a physician, complete lab work, undergo chemotherapy and receive radiation all in one place.

The ECCC is one of only 106 programs in the nation to receive the Outstanding Achievement Award from the Commission on Cancer of the American College of Surgeons in 2011. This award recognizes cancer programs that promote excellence in providing quality care to patients, and the ECCC is the only facility in the Tri-State to receive it.

### **COLLABORATION WITH MARSHALL UNIVERSITY'S JOAN C. EDWARDS SCHOOL OF MEDICINE**



Collaboration with an academic medical center sets the ECCC apart from other area cancer centers. Oncologists at the ECCC train future oncologists, also known as fellows, so they must

maintain up-to-date medical knowledge and provide research-proven care. Patients also have access to a wide array of other medical professionals associated with the University's medical school and clinical trials that may not be available elsewhere in the area.

Marshall University's Charles H. McKown Translational Genomic Research Institute is located on the top floor of the Edwards Comprehensive Cancer Center. Allowing basic scientists to work in close proximity to clinicians encourages collaboration, new research ideas and clinical applications with the rapid translation of research that improves patient care.



### **MEDICAL ONCOLOGY**

Medical oncologists are specially trained doctors who treat cancer and care for patients from diagnosis throughout the course of the disease, discussing and

individualizing treatment options and monitoring care and treatment. Medical oncologists plan cancer treatments involving the use of chemotherapy, hormonal agents and/or biological therapy. The infusion center allows patients to receive their chemotherapy infusions adjacent to the oncologists' offices.



### **RADIATION ONCOLOGY**

Radiation oncologists are the doctors who oversee the treatment of cancer with radiation therapy treatments, monitor progress and adjust the treatment as necessary to make

sure the radiation is hitting its target while minimizing side effects. Radiation can be delivered in two ways, externally and internally. External beam radiation is administered by a machine that produces high energy X-rays. Great care is made to maximize the dose to the cancer and minimize the dose to normal tissues. Internally, high dose rate brachytherapy (HDR) can be administered for many cancer sites, including gynecologic cancers, some breast cancers and other areas in which a high dose of radiation is required for cancer treatment.



### **SURGICAL ONCOLOGY**

Surgical oncologists are surgeons with additional training specific to treating cancer. Wade G. Douglas, MD, is the only fellowship-trained surgical oncologist in the Tri-State area, and he is one of only

about 10 surgeons in the country with fellowship training both in general surgical oncology and surgical head and neck oncology. Dr. Douglas is trained to provide minimally invasive techniques, including robotic surgery.



### **COMPREHENSIVE BREAST CENTER**

Patients with breast cancer, suspected to have breast cancer or who are at high risk to develop breast cancer are provided comprehensive care

and treatment in a compassionate and timely manner by an experienced and caring staff. The Diagnostic Breast Center has been accredited by the prestigious National Accreditation Program for Breast Centers (NAPBC). Surgical breast oncologist Shawn McKinney, MD, FACS, is the area's only surgeon to complete a fellowship in treating breast cancer. The Diagnostic Breast Center offers genetic testing and care for women at high risk to develop breast cancer. All of the nurses are certified in oncology nursing and three serve as nurse navigators for breast cancer patients. All mammogram exams are performed using digital mammography. Stereotactic and digital ultrasound biopsies are also performed in the center.



#### **GYNECOLOGIC ONCOLOGY**

Dr. Gerard Oakley is a gynecologic oncologist, a physician who has completed a fellowship in the care of women with reproductive cancer. Dr. Oakley provides the

latest in diagnostic and treatment services for women with possible pre-cancer or cancers of the reproductive tract. The most common of these cancers involve the uterus, ovaries and cervix, although any part of the female reproductive tract may be involved. He is trained in using the da Vinci® surgical system for some procedures for gynecologic cancers.



#### **UROLOGIC ONCOLOGY**

Urologic oncologists treat cancers that develop in organs of the urinary system or the male reproductive system. Dr. James Jensen, the region's only fellowship-trained urological oncologist, focuses on treating urologic

cancers while preserving normal function. He is one of the most experienced da Vinci® urologic oncologists in the nation, offering minimally invasive surgery with smaller incisions and greater accuracy for better outcomes.



#### **ORTHOPEDIC ONCOLOGY**

An orthopedic oncologist provides specialized care for patients with cancerous and non-cancerous tumors in their bones and muscles, including limb-sparing reconstructions and bone

transplant procedures for patients who otherwise may have been treated with amputations. Dr. Felix Cheung is the region's only board-certified orthopedic surgeon who is fellowship trained in musculoskeletal oncology. He treats both adults and children with benign and malignant tumors in bones and connective tissue. He also specializes in metastatic bone disease, applying the latest research that may prolong or improve quality of life.



#### **PEDIATRIC ONCOLOGY**

A pediatric oncologist is a pediatrician who has completed additional training in treating children with cancer. Dr. Mark Mogul, who is board-certified in pediatric hematology/oncology, directs

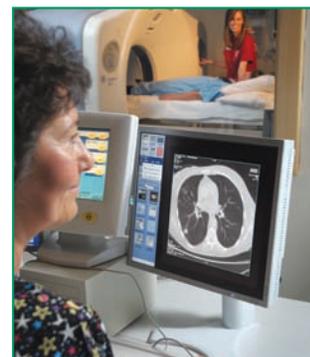
the pediatric oncology program, which is housed on the second floor and features its own waiting area and separate treatment areas for children and adolescents. The Ronald McDonald House on the CHH campus helps families stay close to children during treatment.

#### **MULTIDISCIPLINARY LUNG CANCER CLINIC**



Physicians with expertise in all areas of lung cancer treatment are available to each lung cancer patient in one visit, providing a multidisciplinary approach to treatment. This program is the first of its kind in the

region. The medical oncologist, pulmonologist, radiation oncologist and thoracic surgeon—all of whom play a vital role in treating lung cancer—may evaluate the patient during the first visit. The physicians then collaborate to develop a plan of treatment. A nurse navigator provides much-needed guidance, education and support to patients throughout their entire treatment experience, including scheduling of appointments, tests and procedures.



#### **THE COMPREHENSIVE LUNG NODULE PROGRAM**

The Comprehensive Lung Nodule Program is a fast track to diagnosing and treating small round growths sometimes found in the lung. These lung nodules should be considered serious and could

be a type of early stage cancer. This program brings physician experts and cutting-edge technology together to deliver timely, convenient diagnosis and care to patients with lung nodules. Patients can refer themselves for evaluation or be referred by a physician. An appointment will be made within a few days and a pulmonologist will review the radiology images and discuss the findings and any additional testing needed. The lung cancer nurse navigator will stay in touch with the patient for follow-up care.

#### MULTIDISCIPLINARY COLORECTAL CANCER CLINIC



At the ECCC, a multidisciplinary approach is also used in treating colorectal cancers. On the first visit, patients are seen by the surgical oncologist, medical oncologist and

radiation oncologist. The physician specialists then meet to establish a plan of care, and the plan is discussed with the patient before leaving the first visit. Because this takes place in one location, all medical records are accessible to all the physicians involved in that patient's care.

able to offer major Phase II and III clinical trials to Tri-State cancer patients that may improve their overall outcome and contribute to the future of cancer care. The ECCC is also able to offer pediatric trials through participation in Children's Oncology Group trials.

#### SUPPORT GROUPS

All support groups are free, and they meet in the Edwards Comprehensive Cancer Center on the Ground Floor.

- Sharing Support Group is for women surviving ovarian, cervical or any other gynecologic cancer. It meets at 5:30 p.m. on the first Monday of each month. Questions? 304-526-2443
- Sisters of HOPE is for women surviving breast cancer. It meets at 5:30 p.m. on the third Monday of each month. Questions? Call 304-526-2443.

For more information about cancer support groups please contact Gigi Gerlach, RN, at 304-526-2443 or [gigi.gerlach@chhi.org](mailto:gigi.gerlach@chhi.org). For more information on the services provided by the ECCC, please visit our web page at <http://edwardsccc.org>.



#### CLINICAL TRIALS

Ongoing research is essential in the fight against cancer, and it is one of the major objectives of the ECCC. As a member of the North Central Cancer Treatment Group (NCCTG), the ECCC is



*A Distinct Difference in Cancer Care.*