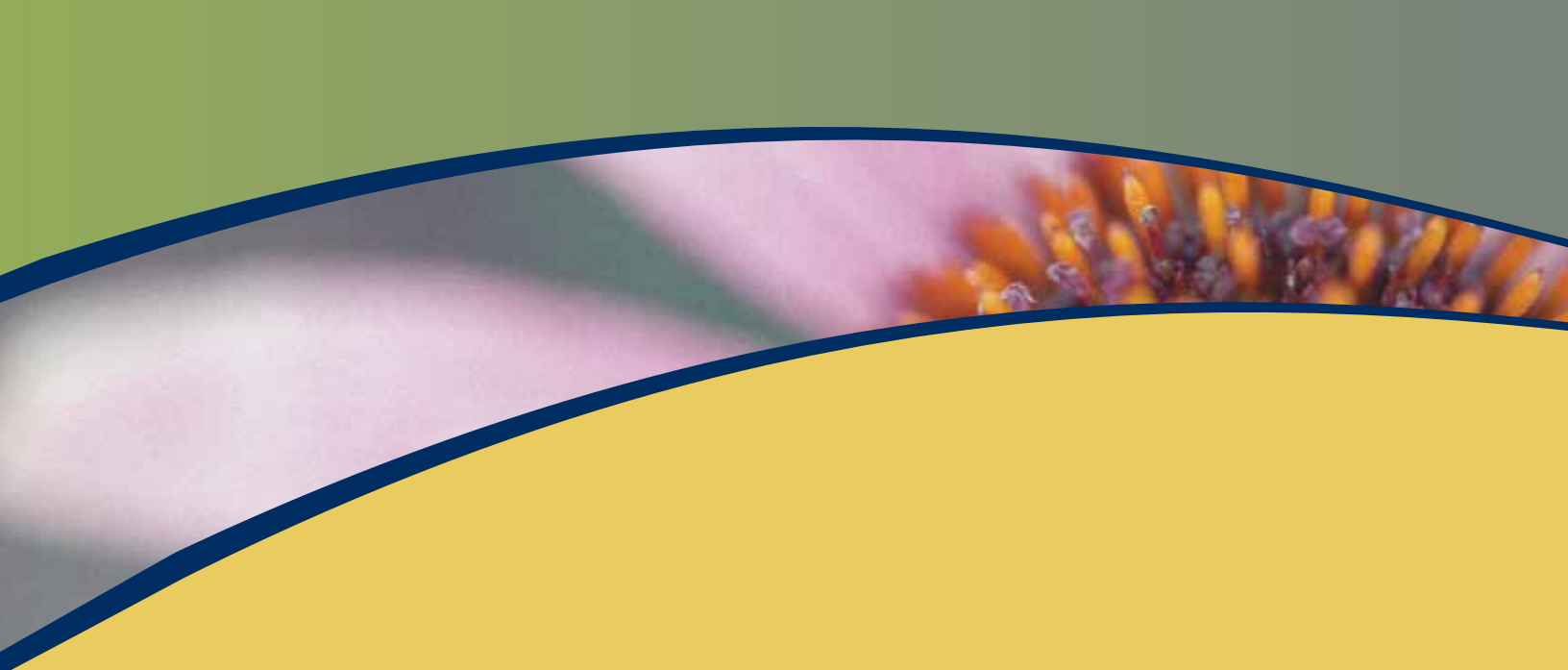


# Central Maine Comprehensive Cancer Center



*2008 Annual Report*

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## Cancer Committee

### CHAIRMAN'S REPORT



*I again wish to thank everyone involved with the CMMC Cancer Center for a very successful 2007. Leading the way, and with heartfelt appreciation from Dr. Erickson, CMMC has added two medical oncologists, Dr. Meghna Desai and Dr. Ann Traynor to the staff.*

Their contributions to the medical oncology clinic, the inpatient unit and the community in general have already been felt. CMMC has also made big strides to the cancer program by adding digital mammography to the radiology unit, a technology that has proven to detect more early breast cancers, thereby increasing success rates for treatment of these smaller breast cancers. Other additions during this calendar year include a new oncology social worker, Dorn McMahon, and a new medical oncology PA Gisele Castonguay, the increased role of the Dempsey Center and the completion of renovations in medical oncology that have expanded exam rooms, work space and research area. The department of radiation oncology has further implemented a new IMRT treatment planning computer expanding normal tissue sparing treatment to breast patients, and received approval from the RTOG as a protocol treatment center. All these advances have increased our ability to reach out to patients, cancer community and offer state of the art treatment. Next year's letter will surely add to the advancements.

A handwritten signature in black ink, appearing to be a stylized 'f' or similar character.

CANCER COMMITTEE  
CHAIRMAN'S REPORT  
*continued...*

#### 2007 BREAST CARE CONFERENCES

|                                |     |     |       |
|--------------------------------|-----|-----|-------|
| Number of Conferences          | 25  |     |       |
| Number of Cases Presented      | 182 |     |       |
| Number of Prospective Cases    | 61% |     |       |
| Number of Cases without Cancer | 9   | 6%  |       |
| Average Attendance             | 11  | 272 | Total |

|                      |     |     |  |
|----------------------|-----|-----|--|
| <i>Physicians</i>    | 219 | 81% |  |
| <i>Allied Health</i> | 30  | 11% |  |
| <i>RN/FNP</i>        | 23  | 8%  |  |

#### 2007 TUMOR BOARD

|   |     |     |       |
|---|-----|-----|-------|
| Number of Conferences                   | 27  |     |       |
| Number of Cases Presented               | 121 |     |       |
| Number of Prospective Cases             | 120 | 99% |       |
| Number of Follow-Up/Retrospective Cases | 2   | 1%  |       |
| Average Attendance                      | 20  | 481 | Total |

|                      |     |     |  |
|----------------------|-----|-----|--|
| <i>Physicians</i>    | 302 | 63% |  |
| <i>Allied Health</i> | 138 | 29% |  |
| <i>RN/FNP</i>        | 41  | 8%  |  |

#### 2007 THORACIC CONFERENCES

|                                |     |     |       |
|--------------------------------|-----|-----|-------|
| Number of Conferences          | 20  |     |       |
| Number of Cases Presented      | 107 |     |       |
| Number of Prospective Cases    | 84  | 79% |       |
| Number of Cases without cancer | 23  | 21% |       |
| Average Attendance             | 10  | 201 | Total |

|                      |     |     |  |
|----------------------|-----|-----|--|
| <i>Physicians</i>    | 171 | 85% |  |
| <i>Allied Health</i> | 12  | 6%  |  |
| <i>RN/FNP</i>        | 18  | 9%  |  |

**The Cancer Registry at CMMC continues to track a steady state of cancer statistics with 805 analytical cases registered over the 2007 year. These are cases that are diagnosed and/or received all or part of their first course of treatment at CMMC. Cases are reported to the Maine Cancer Registry as well as to the American College of Surgeons.**

Every three years the Cancer Program, including the Registry, is evaluated by the American College of Surgeons. In 2007 the program was rewarded with a three year approval award with commendation. The Cancer Registry and Registrars were also commended for their exacting, high standards.

As in the past, breast, lung and prostate cancers remain the most common diagnosed cancers at CMMC with incidences of 20.1%, 18.6%, and 14.4% respectively. These incidences are reversed when compared to national statistics of 12.5%, 14.8% and 15.1%. One could speculate that our higher incidence of breast cancer cases is likely due to CMMC's status as a regional referral center.

It can also be noted that lung cancer incidences at CMMC remain higher than the estimated National 2007 percentages. This is a trend noted in our registry that has continued over many annual comparisons and is expected given the higher incidence of only 5% smoking in the community.

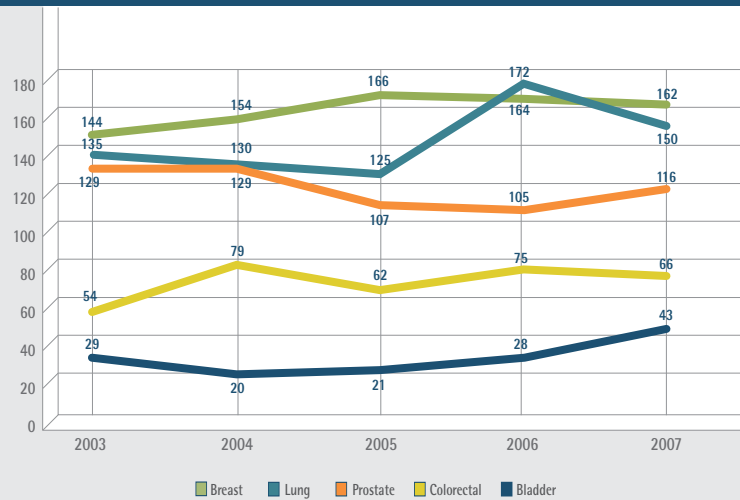
## As in the past, breast, lung and prostate cancers remain the most common diagnosed cancers at CMMC.

As noted in the past, the top three diagnoses continue to comprise just over 50% of all analytical cases. Of interest, non hodgkin's lymphoma and primary central nervous system malignancies showed a significant decrease in incidence. In 2005 and 2006 Central Maine Medical Center's Registry noted 26 and 25 Non-Hodgkin's Lymphomas but in 2007 only 15 cases. And the 1.9% of all analytic cases was lower than the 4.4% national incidence. For Central Nervous System primaries, the 2005 and 2006 numbers registered were 17 and 16 but in 2007 only 5 cases. This is a 1.6% CMMC versus 1.4% National difference. Other sites remained relatively consistent within the total percentage of cases diagnosed as noted in the tables and graphs displayed.

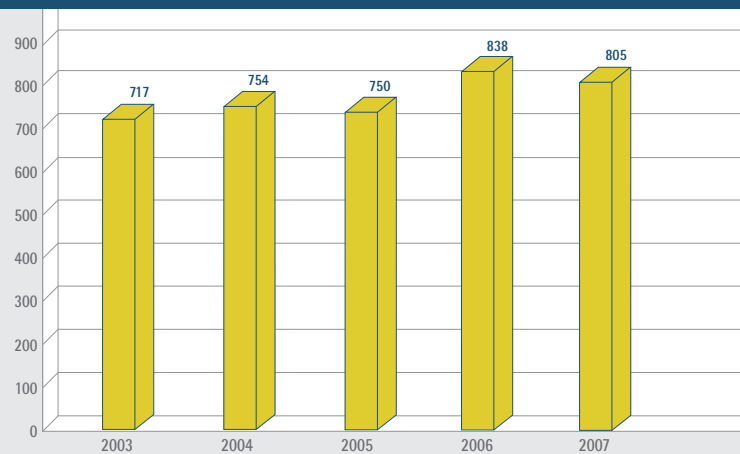
Lastly I would like to thank all the Registrars involved for a job "well done". Their help and expertise in data collecting and abstracting allow CMMC to continue to provide a wealth of information for community and national studies. This allows the involved medical personal to continue our goals of establishing and maintaining excellent patient care.



### MOST FREQUENT CANCERS PAST FIVE YEARS



### TOTAL ANALYTIC CASES PER YEAR



Complete Registry Total = 9,801 Cases (Reference Date = 1995)

Follow-up Rate = 94% (Target Rate is 80%)

Alive Follow-up Rate = 96% (Target Rate is 90%)

## 2007 Cancer Incidence Statistics

| Site                                | Number of Cases |            |            | % of 2006 Analytic Cases | Estimated 2006 National Percent | Presented at CA Conference** |
|-------------------------------------|-----------------|------------|------------|--------------------------|---------------------------------|------------------------------|
|                                     | 2004            | 2005       | 2006       |                          |                                 |                              |
| Breast                              | 166             | 164        | 162        | 20.1                     | 12.5                            | 182                          |
| Lung / Bronchus                     | 125             | 172        | 150        | 18.6                     | 14.8                            | 94                           |
| Prostate                            | 107             | 105        | 116        | 14.4                     | 15.1                            | 18                           |
| Colorectal / Anus                   | 62              | 75         | 66         | 8.2                      | 10.9                            | 20                           |
| Urinary Bladder                     | 21              | 28         | 43         | 5.3                      | 4.6                             | 4                            |
| Non-Hodgkin Lymphoma                | 26              | 25         | 15         | 1.9                      | 4.4                             | 7                            |
| Corpus Uteri                        | 11              | 21         | 16         | 2                        | 2.7                             | 1                            |
| Esophagus                           | 14              | 20         | 15         | 1.9                      | 1.1                             | 4                            |
| Thyroid Gland                       | 12              | 19         | 11         | 1.4                      | 2.5                             | 1                            |
| Pharynx                             | 8               | 19         | 17         | 2.1                      | 0.8                             | 5                            |
| Melanoma / Skin                     | 26              | 18         | 24         | 3                        | 4.5                             | 5                            |
| Kidney/Renal Pelvis/Ureter          | 13              | 18         | 29         | 3.6                      | 3.7                             | 5                            |
| Pancreas                            | 16              | 17         | 20         | 2.5                      | 2.6                             | 4                            |
| Brain / CNS                         | 17              | 16         | 5          | 0.6                      | 1.4                             | 0                            |
| Leukemia                            | 21              | 12         | 14         | 1.7                      | 3.1                             | 4                            |
| Stomach                             | 7               | 11         | 14         | 1.7                      | 1.5                             | 3                            |
| Larynx                              | 16              | 9          | 7          | 0.9                      | 0.8                             | 5                            |
| Multiple Myeloma & Plasmacytoma     | 10              | 9          | 6          | 0.8                      | 1.4                             | 1                            |
| Ovary/Fallopian Tube                | 7               | 6          | 1          | 0.1                      | 1.6                             | 2                            |
| Hodgkin Lymphoma                    | 5               | 5          | 7          | 0.9                      | 0.6                             | 3                            |
| Liver~Intrahepatic Bile Duct        | 5               | 5          | 2          | 0.2                      | 1.3                             | 0                            |
| Gallbladder                         | 3               | 5          | 0          | 0                        | 0.6                             | 0                            |
| Bone                                | 1               | 5          | 2          | 0.2                      | 0.2                             | 0                            |
| Cervix Uteri                        | 4               | 4          | 6          | 0.8                      | 0.8                             | 1                            |
| Soft Tissue/Sarcoma                 | 4               | 4          | 5          | 0.6                      | 0.6                             | 0                            |
| Vulva/Vagina                        | 3               | 4          | 3          | 0.4                      | 0.4                             | 1                            |
| Lip & Oral Cavity                   | 4               | 3          | 9          | 1.1                      | 1.4                             | 2                            |
| Penis / Testis                      | 4               | 3          | 1          | 0.1                      | 0.6                             | 0                            |
| Small Intestine                     | 1               | 3          | 4          | 0.5                      | 0.4                             | 1                            |
| Salivary / Parotid Glands           | 0               | 2          | 2          | 0.2                      | 0.1                             | 2                            |
| Eye / Orbit                         | 0               | 1          | 0          | 0                        | 0.2                             |                              |
| Mesothelioma                        | 7               | 0          | 3          | 0.4                      | 0.3                             | 0                            |
| Extrahepatic Bile Duct              | 3               | 0          | 1          | 0.1                      | 0.3                             | 0                            |
| Other & Unknown Unspecified Primary | 14              | 18         | 19         |                          |                                 | 7                            |
| Head, face, or neck, NOS            | 0               | 0          | 1          |                          |                                 | 0                            |
| Myeloproliferative Disorder         | 4               | 0          | 1          |                          |                                 | 0                            |
| Myelodysplastic Disorder            | 3               | 1          | 2          | 3.6                      | 2.2                             | 0                            |
| Nasal Cavity                        | 0               | 2          | 1          |                          |                                 | 0                            |
| Adrenal Gland                       | 0               | 1          | 0          |                          |                                 | 0                            |
| Essential Thrombocythemia           | 0               | 4          | 0          |                          |                                 | 0                            |
| Refractory Anemia                   | 0               | 2          | 1          |                          |                                 | 1                            |
| Polycythemia Vera                   | 0               | 1          | 4          |                          |                                 | 0                            |
| Macroglobulinemia                   | 0               | 1          | 0          |                          |                                 | 0                            |
| <b>TOTALS</b>                       | <b>750</b>      | <b>838</b> | <b>805</b> | <b>99.9</b>              | <b>100</b>                      | <b>383</b>                   |

\* Analytic = Cases diagnosed and/or receiving first course of treatment at CMMC.

\*\* Total presented may be greater than total for site because of multiple presentations or non-analytic cases presented.

2006 United States Estimated New Cancer Cases = 1,399,790

American Cancer Society Facts & Figures 2006

## Treatment of



# BRAIN CANCER



*Brain tumors are uncommon cancers. The term brain tumor can encompass any type of abnormal tissue growth that arises in the brain, or in the meninges, the lining envelope around the brain. It might also refer to cancers that travel to the brain from other sites.*

Malignant tumors that arise in the brain are uncommon cancers that account for about 1.5% of all cancer diagnoses. The most common type of malignant brain tumor in adults is known as glioblastoma. Despite being the most common, glioblastoma has an incidence rate of only 2-3 new cases per 100,000 people every year. The cause of glioblastoma is unknown, with no evidence at this time to link the disease to diet, smoking, cellular telephones, or electromagnetic fields. It is also a very aggressive cancer, with generally poor outcomes.

Between the years 2000 and 2005, forty four patients with glioblastoma were diagnosed or treated at Central Maine Medical Center. In this report, we will compare our patient population with national data and assess outcomes. This disease is diagnosed more commonly among men, and survival is usually not as good for men. The causes for this are not known. Our experience at CMMC are similar in that 28 of our 44 patients were male, a male predominance which is seen nationwide. However, survival for our male patients was slightly better than for the female patients. This may reflect the relatively small sample size.

Survival for this disease is generally very short without treatment, measured in just a few months. Even with treatment that includes surgery, radiation and chemotherapy, most people will live for less than one year from the diagnosis. The most important factor in predicting survival is age. Increasing age at the time of diagnosis is a predictor of shorter survival times. The survival curves of our patients, assessed by age at diagnosis, very clearly demonstrate the significance of this risk factor. Only



**In clinical trials, when bevacizumab was combined with chemotherapy, it led to significant tumor shrinkage for the majority of patients who received the treatment.**

patients diagnosed under the age of 60 had a median survival of at least one year. Our older patients had median survival times measured in months.

The reasons for such poor survival for this disease are many. These types of brain tumors will extend into the brain tissue with finger-like projections, much like the roots of a plant extend into the soil. This means that even when surgery appears to remove the entire tumor, there will be microscopic cancer cells left behind. In addition, brain tumors have been relatively resistant to other conventional cancer treatments such as chemotherapy.

Treatments for glioblastoma are palliative, meaning that they are not capable of curing the cancer but are done to alleviate symptoms and to prolong life. Whenever possible, removal of as much tumor as possible is done by a neurosurgeon. Removal of more than 98% of the tumor, called a "gross total resection," is associated with improved survival. Even if the bulk of the tumor cannot be removed, sometimes removing even part of the tumor may be important to reduce symptoms or swelling in the brain. Sometimes the tumor is located in a part of the brain where surgery would cause more neurologic damage, and in those cases, surgery cannot be performed.

Surgery is usually followed by radiation therapy, often in combination with a chemotherapy pill, temozolamide. If surgery cannot be performed, then radiation is the primary form of treatment. Intensity Modulated Radiation therapy, or IMRT, is an advanced radiation delivery system used at Central Maine Medical Center to treat brain tumors. IMRT uses an advanced computer system to plan a precise dose of radiation in three dimensions based

on a tumor's size, shape, and location. It allows greater accuracy in targeting the tumor and sparing more of the surrounding healthy tissue. Radiation is delivered over six weeks, given daily Monday through Friday for thirty treatments.

Recent advances in medical therapy include very promising improvements in patients treated with bevacizumab (Avastin, Genentech). Bevacizumab is a biologic therapy designed to interfere with blood supply to the tumor. In clinical trials, when bevacizumab was combined with chemotherapy, it led to significant tumor shrinkage for the majority of patients who received the treatment. It is hoped this will lead to improved survival for patients facing an otherwise grim diagnosis.

## Bennett Breast Care Center

### CELEBRATES 10TH ANNIVERSARY



*The staff of the Breast Center met recently at DaVinci's restaurant to celebrate our 10th anniversary. As we enjoyed the dinner and good company we couldn't help but wonder that many of the services and treatments we now take for granted were considered almost revolutionary such a short time ago. Perhaps a brief look back will serve both to celebrate our success as well as stimulate us to seek further improvement.*

The concept of the "Breast Care Center" was quite new to Maine and the nation in 1996. Nonetheless, several local physicians had become acquainted with the concept through discussions at regional and international conferences on breast cancer. Dr. Pam Rietschel, who has since remained my respected colleague and co-medical director of our center, was energized by these discussions. She decided that creation of such a center at CMMC would be of tangible benefit to our patients with newly diagnosed breast cancer. She approached me and other surgeons and administrators with these ideas, and was met with surprising levels of cooperation and enthusiasm. Jack May, then director of clinical services, was excited at the prospect and soon Dr. Rietschel and I had joined him for a tour of the St. John's Breast Center, a nationally recognized center of excellent breast health care delivery in St. Louis, Missouri. Despite some criticism and negativity from various segments of the multidisciplinary spectrum in Lewiston, we soon had passed from feasibility study to implementation. With the hiring of our nurse practitioner Kathi Varney, and the construction of a state of the art facility we were on the threshold of some great improvements in breast cancer care.

But what, really, were the vital changes in cancer care that we envisioned, and how successful have we been in meeting our goals?

It's important to remember how different the breast cancer diagnosis and care paradigm was in those days. Of course we had the appropriate access to the various physicians and facilities involved in provision of breast cancer care in 1996. Surgeons, radiologists, pathologists, medical and radiation oncologists all had their role to play, and

generally they did it adequately. But there was little coordination of effort. Since there was no unified mechanism to bring the consultants together, the care was dependant on communication that was often far from optimal. The pace of diagnosis and treatment of newly identified breast cancer was often too slow. Moreover, there was no uniformity in the care provided. Some physicians were exceptionally current in their knowledge base, and others were less informed.

So two of these critical needs were addressed by creation of a multidisciplinary group of physicians dedicated to prospectively reviewing each and every one of our new breast cancer cases. The goal of expediting and coordinating care was greatly facilitated by this group, who continue to meet regularly to discuss individual cases. In order to address the physician specific issues mentioned above we established minimum ongoing education requirements for all physicians involved with our patients. In addition, mostly by dint of diligent work by Dr. Rietschel, we established care protocols for a wide variety of breast health related problems. These include invasive and non-invasive cancer, premalignant conditions, genetic issues, as well benign diagnoses such as mastalgia (breast pain), gynecomastia (male breast enlargement), nipple discharge and others. Through use of these protocols we believe that our care has become more uniform and more firmly based on scientific evidence rather than tradition. Ongoing peer review based on these protocols has, I firmly believe, made our care the best in the state. Updating these protocols represents a major investment in time and energy, so we know we can't "rest on our laurels". Nonetheless, we're really proud of this aspect of our breast care center. We

believe this feature alone places us at the pinnacle of breast cancer care.

Interestingly, the goal of speeding the process from diagnosis to treatment has undergone some modification over the years. We've been fortunate that our talented plastic surgeon, Stephen Bonawitz, has made it a priority to schedule an expeditious consult whenever we've asked for it, so there has been little delay in that area. However, the recent addition of breast MRI, genetic testing, and axillary ultrasound to the pre-op evaluation led to some unavoidable delays in management. At times we got an unexpected lesson in sensitivity, such as when we learned that some women were "feeling rushed" about making decisions regarding cancer surgery. So our goal of proceeding from diagnosis to inception of treatment in one week has undergone considerable modification. Like so many other aspects of breast cancer management we now do our best to individualize the pace of the workup and treatment plan. Our key priorities remain unchanged: we seek to provide optimal, scientifically sound care in a manner that leaves our patients pleased at our expertise as well as our sensitivity to their individual needs.

| BENNETT BREAST CENTER PATIENT ENCOUNTERS |      |      |        |        |
|--|------|------|--------|--------|
| Year                                     | 1998 | 2000 | 2006   | 2007   |
| <b>Mammograms</b>                        | 1600 | 5500 | 8200   | 8500   |
| <b>US</b>                                | 150  | 550  | 1100   | 1200   |
| <b>Consults</b>                          | 180  | 750  | 1233   | 1255   |
| <b>Stereo biopsy</b>                     | 80   | 130  | 155    | 200    |
| <b>US biopsy</b>                         | 0    | 30   | 53     | 61     |
| <b>Total Patients</b>                    | 2500 | 7750 | 11,300 | 12,303 |



**Our goal of proceeding from diagnosis to inception of treatment in one week has undergone considerable modification.**

As we approach the new fiscal year we are delighted to see the addition of new and upgraded services for our patients.

The mobile Positron Emission Tomography (PET) scanner that has been utilized at CMMC for the past three years was replaced by a PET/CT scanner in October 2007. The scanner, which is operated by Alliance Imaging, scans patients between two to three days a week. Most of the applications of PET/CT are in the initial diagnosis and staging of cancer. This current technology performs a CT scan of the whole body, which is combined with a whole body scan performed after the injection of an isotope that is taken up by metabolically active tissues. These studies have been shown to be very accurate in cancer staging. In many cases, PET/CT replaces the radionuclide bone scan. Frequently this fused scan will detect lesions not apparent on the CT scan alone.

Two digital mammographic units were installed in August 2008 in the Sam and Jennie Bennett Breast Care Center. These units are equipped with computer-aided diagnosis (CAD). This allows a double read to be performed by the computer on every mammogram. Digital mammography has been proven to improve breast cancer detection rates in patients with mammographically dense breasts. Most premenopausal patients have such findings, so digital mammography is especially useful for them. With continued experience we expect digital techniques to eventually result in improved breast cancer detection in all patients. Digital mammography also provides patients with a quicker visit to the breast center since films are processed more rapidly than conventional mammograms. Inherently,

digital mammography imparts a lower radiation dose to the patient. We have also purchased a filter that further reduces the radiation dose.

Perhaps the greatest benefit of digital technology relates to portability of the images. The digital component will allow electronic transfer of the patient's studies to any location. As the studies are stored digitally, the possibility of lost films will be prevented. CMMC was fortunate to receive an Avon grant. This will allow for the purchase of digital mammographic units at both Rumford and Bridgton hospitals. These units will be purchased and installed over the next several months.

In addition, our long awaited upgrade in ultrasound technology was recently activated. This gives our center a technologic "facelift" that keeps us at the highest level of quality in the state, region and nation.

Also, it should be noted that radiologists at CMMC continue to play a central role in the Breast Center's success. Dr. Schraft has been on the Bennett Breast Care Advisory Committee since its inception. She was involved in early planning after visiting St. Joseph's Breast Care Center in Springfield, Missouri. Dr. Schraft and her colleagues spearheaded the stereotactic breast biopsy program at this hospital approximately 15 years ago, acquiring the first stereotactic biopsy unit in the state. The late Sam and Jennie Bennett, who provided major funding for the Breast Care Center, are the parents of Dr. John Bennett, a senior member of the Imaging Department at CMMC.

## Central Maine Healthcare

### STANDARDIZES CHEMOTHERAPY & BIOTHERAPY TRAINING

#### **Central Maine Healthcare Nurses continue to make great strides in their efforts to provide high quality, consistent education to those involved in the handling and administration of chemotherapy and biotherapy.**

To date, greater than 30 nurses have completed the Oncology Nursing Society's Chemotherapy & Biotherapy Course held at the Central Maine Medical Center Campus. The course is based on the latest edition of the Oncology Nursing Society's Chemotherapy and Biotherapy Guidelines and Recommendations for Practice and is a comprehensive review of the best practices and knowledge needed to administer chemotherapy and biotherapeutic agents. Topics include cellular kinetics, cytotoxic principles, classification of cytotoxic therapeutic agents, safety issues related to drug administration, and nursing assessment and management of the patient receiving therapy. The two day course provides nurses with 13.5 contact hours in addition to an extensive understanding of providing the best possible care to our patients with cancer.

In addition to the course each nurse is required to demonstrate competence at the hands on skill lab held yearly at Central Maine Medical Center. This lab was established as a joint effort between the outpatient and inpatient areas in order to ensure consistent education and practice across the continuum of patient care. Topics of the skill lab include patient education, protocol recognition, dose calculation, safe handling and disposal of chemotherapeutic agents, and simulated administration scenarios.

Tamara English, RN, MSN OCN is an official trainer for the ONS Chemotherapy and Biotherapy Course. In addition to teaching the course, Tamara works out of the Hematology Oncology office of Dr's Erickson, Traynor, and Desai where she has greater than 10 years of professional experience in the areas of Chemotherapy and Biotherapy administration.

The impact of all these qualities hasn't been lost on area physicians and patients. We've seen a fairly steady increase in numbers of consults, imaging studies, biopsies, etc. over the years:

While the majority of our patients reside in the Lewiston-Auburn area we've been pleased to see that our "geographic impact" has also expanded. Over the ten years since our inception there has been a clear trend toward increased referrals from outlying communities in Maine. For example we've seen a three fold increase in patients arriving from the Augusta/Gardiner region.

As we enter our second decade we take pride in our accomplishments while looking ahead to new challenges. We hope with some confidence that our best successes in the treatment and prevention of breast cancer lie before us.



Gregory D'Augustine

## Giving Back

# THE CREATION OF THE PATRICK DEMPSEY CENTER FOR CANCER HOPE & HEALING

*at Central Maine Medical Center*



BY KERRY IRISH, LCSW, OSW-C & RITA MOLLOY

### The Setting

The Patrick Dempsey Center for Cancer Hope & Healing at Central Maine Medical Center is the newest service within a healthcare system that has long been celebrated for its innovative and compassionate healthcare services. Central Maine Medical Center (CMMC) is a 250 bed tertiary facility and Level II Trauma Center which provides healthcare services, health professions training, and clinical research opportunities across a vast region of predominantly rural and economically depressed western and central Maine. Collectively, the primary and secondary tertiary hospital service area extends from upper Franklin County in the north, to upper Cumberland County in the south, west to New Hampshire, and east to the coast. This is Maine's 'central tier'. Under the organizational umbrella of Central Maine Healthcare (CMHC), CMMC is affiliated with the Central Maine Heart and Vascular Institute, and the CMMC College of Nursing and Health Professions, and two rural Critical Access hospitals (Bridgton Hospital and Rumford Hospital).

Among CMMC's many specialties is cancer care, provided under the umbrella of the Comprehensive Cancer Center. The Center provides a wide range of services to area cancer patients, including diagnostic, treatment, support, end-of-life, and information services. Through its research relationship with the Dana-Farber Cancer Institute in Boston, the Cancer Center also provides opportunities for cancer patients to participate in cutting-edge oncology clinical trials.

### The Impetus for Establishing the Patrick Dempsey Center

The primary service area of Central Maine Healthcare is Androscoggin, Oxford, and upper Cumberland counties in the western and central parts of the state. The predominant census designation of the towns in the service area is rural or exceptionally rural, with a very few minor

..... 66 .....

**Located on the CMMC campus,  
the Dempsey Center  
provides support, education, and  
health promotion for  
those touched by cancer.**

**Development on the entire project proceeded quickly over the course of 14 months, and with a generous seed donation from Mr. Dempsey...**

urban clusters, and one urbanized area, the twin cities of Lewiston/Auburn, whose combined 2008 estimated census is now around 64,000.

Transportation in the region has always been considered a barrier to care for those who cannot afford a car, the cost of gasoline, or the price of hiring someone to transport them. A round trip to and from CMMC from within this area can entail up to 100 miles of driving over poor east-west secondary and rural roads. Public transportation in the region is virtually non-existent, and volunteer transport and small regional call-for-service organizations are spread thin.

The population in the CMMC service area includes both an insured working population and a large sub-set of poor, uninsured, aging, and chronically ill. The population in Maine, as in other parts of the country, is aging. Over the next decades the Baby Boomers will continue to join the current elderly in record numbers, entering the prime years for developing chronic and other illnesses, including cancer. In 2004 people aged 45 and older represented 39% of Maine's population. By 2025 this segment will rise to 47%. Those aged 65 and older will rise from ~14% to 21%. In the Lewiston/Auburn area alone, 17.8% of the population is age 65 or older, as compared to 14.4% for Maine and 12.4% for the US.


During the period 2004-2005, 124,000 Mainers did not have health insurance. The majority of these were adults, and half of them were from low income families. Additionally, research has shown that nationally, "rural families, particularly those living in counties not adjacent to urban counties, are more likely to have an uninsured member (33% of rural non-adjacent families versus 28% urban), and to have all members uninsured (9% rural non-adjacent versus 6% urban)." The service area of CMMC / CMHC is predominantly rural.

Across the service area there remains a lack of cancer support services. Patients in the outlying rural clinics

still have very limited access, if any, to live cancer support groups, and no access to professional oncology social work or cancer patient navigation services.

**The birth of the Patrick Dempsey Center**

Patrick Dempsey, the well-known actor who currently plays a doctor on the hit television show, Grey's Anatomy, grew up in central Maine, and his mother received cancer care at CMMC. During her illness, the family relied upon Dempsey's sister, Mary, a medical secretary and patient access specialist who has worked at CMMC for over 25 years, to help them navigate the complexities of the healthcare system. In early 2007, Patrick and Mary approached CMMC about the possibility of supporting an expansion of support offerings for individuals with cancer. A steering committee comprised of hospital administrators, oncology program staff, several physicians, development staff, and Mary, as a representative of the Dempsey family, was formed to explore and discuss the needs of cancer patients and caregivers in the Central Maine region. The outpatient oncology social worker compiled data that has been collected over the past 4 years from an initial patient needs survey tool (based on the NCCN's distress screening tool & problem checklist), which is provided to all new oncology patients of the Comprehensive Cancer Center. The oncology social worker also conducted an informal needs assessment/focus group with members of the Cancer Wellness & Support Group to assess their perceived information and support needs. The input of oncologists and other physicians who work with cancer patients was also solicited, as was that of the two rural oncology clinic managers. Within months, the concept had coalesced to one of developing a cancer resource and education center on the CMMC campus, with satellite services being provided in the oncology clinics of the rural Critical Access hospitals. The steering committee and Patrick himself all agreed that creating a strong web-based component to the program was also critical. While some patients and families who live in the Central Maine catchment area are not able to travel regularly to the Dempsey Center or the



outlying oncology clinics for Center programs and services, virtual services that can be provided through a website are always available to those who have web access. A website development committee, comprised of medical librarians, communications office staff, and oncology professionals was formed. This group developed a blueprint and content (and/or contracted with other reliable sources for cancer information) for the original website, then worked with website designers and programmers in order to launch an attractive, easily navigable site in time for the Center's opening. At present, the website serves mainly as a source for reliable information about cancer (the 3-D Cancer Atlas videos, created by Blausen Medical Communications, inc., which provide information about different types of cancer, treatment, and procedures are an especially popular feature), as well as highlighting programs and services available through the Center. Further website development plans are in progress.

In addition to the work of the steering committee, it was decided that use of an ongoing Professional Advisory Committee to help guide the planning, implementation, and evaluation process of the Center's programs and services, would be a valuable undertaking. The Professional Advisory Committee is comprised of individuals who live and/or work within Central Maine, including at least two members each from the Bridgton and Rumford communities. Committee membership includes at least two cancer survivor(s) and/or family caregiver(s), and a balanced representation of relevant professional disciplines, including a physician; a clinical psychologist; an oncology social worker; an oncology nurse; a chaplain, clergy member or pastoral care associate; a medical librarian; a radiation therapy professional, a representative from CMMC administration; and Patrick Dempsey (who actively participates in each meeting by conference call). This committee began meeting in early January 2008, and accomplishments to date have included the development of the Center's mission statement (see below) as well as a priority slate

of program and service goals and ideas. The committee recently reviewed the brief of the Institute of Medicine's report on Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs, and discussed how the Patrick Dempsey Center and our larger institution, Central Maine Medical Centers' missions and services currently align with the report's recommendations, and how we might continue to refine and improve the psychosocial care of cancer patients and their caregivers.

**In addition to the website and the cancer resource center, The Dempsey Center also provides:**

- *Professionally-facilitated cancer and caregiver support groups both at CMMC and in outlying communities.*
- *Integrative Medicine Programming and classes, such as therapeutic massage services, yoga, qi gong, and more.*
- *A toll-free Cancer Assistance Line providing information about local, state, and national resources and services for those living with cancer.*
- *A dedicated outreach oncology social worker to provide counseling, case management, support groups and educational programs in the outlying rural communities where people are often underserved.*
- *Community health education offerings on cancer-related topics, such as a recent, well-attended public screening of the film *The Breast Cancer Diaries* and panel discussion with breast cancer patients and experts.*

Development on the entire project proceeded quickly over the course of 14 months, and with a generous seed donation from Mr. Dempsey, The Patrick Dempsey Center for Cancer Hope & Healing opened on March 31, 2008.

Located on the CMMC campus, the Patrick Dempsey Center provides support, education, and health promotion for those touched by cancer. Its warm, inviting environment includes a cancer resource library with a dedicated computer station for patient/public use that allows internet access to virtual cancer resources, an integrative medicine treatment room, and dedicated space for cancer support group meetings and educational programs.

Nearly all of the services of The Patrick Dempsey Center for Cancer Hope & Healing are free of charge. Some integrative medicine services (massage therapy, for example) require a very modest fee for service, based on a sliding fee scale. Current funding for services and programs comes from Mr. Dempsey's initial donation, support from Central Maine Medical Center, and from other philanthropic sources, including donations from the public. Future development opportunities, including grants and fundraising events, are being explored.

### **Our Mission Statement**

The mission of The Patrick Dempsey Center for Cancer Hope & Healing is to provide the highest quality of education, support and wellness services to enhance the quality of life of individuals, families, and communities touched by cancer. We strive to embrace the whole person, including body, mind, and spirit, in a respectful, inclusive, and healing environment.

### **Future Directions**

As interest in The Center grows, we are fielding many requests for additional programs and services, including expanded integrative medicine offerings, direct patient financial assistance programs, and services for post-treatment cancer survivors and their family members.

With a small staff (a Program Director, Center Coordinator, and Outreach Oncology Social Worker) and a large

mission, we are striving to achieve funding levels which will support the provision of additional programs and services, while simultaneously utilizing existing resources, such as oncology program staff, our Professional Advisory Committee, and a growing pool of capable and enthusiastic volunteers, to meet our initial program goals. In the fall of this year, we plan to launch a Patient Financial Assistance Counseling program to help cancer patients manage the financial crisis that a cancer diagnosis can precipitate. We are also hoping to expand our transportation assistance program, to help patients overcome the significant barriers that can prevent one from accessing timely workup and treatment for cancer.

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# TAMOXIFEN STUDY



*In 2004, a collaborative team of radiation oncologists, surgeons, medical oncologists, and, led by the Radiation Oncology Therapy Group (RTOG), published a trial attempting to address the role for post-operative radiation breast cancer patients greater than 70 years old.*

Previous data and conventional wisdom hypothesized that breast cancer in this elderly population may be less aggressive than in younger patients and potentially require less treatment.

The trial included 636 patients, all greater than 70 years of age and all with tumors less than 2 cm that were completely surgically resected. The trial only included estrogen receptor positive patient and randomized women to either Tamoxifen alone vs. Tamoxifen plus a traditional six week course of radiation to the breast. The only significant difference between the randomized groups was a 1% control rate for the irradiated group and a slight decrease in local control to 4% for the non-irradiated group. All other categories (rate of salvage mastectomy, distant metastasis, and 5 year overall survival) shared no significant improvement with past operative radiation. The small improvement in local control, while statistically significant, has been interpreted by some to be of little clinical significance as the vast majority of the elderly population die from causes other than breast cancer. The addition of Tamoxifen appeared to have a key role in reduction of local failure when compared to the previous sub-groups who avoided both radiation and Tamoxifen.

Because of the above new data, and after a consensus conference of all involved breast cancer physicians, CMMC began in 2006 to offer patients the potential option of lumpectomy and Tamoxifen, without traditional radiation, if all criteria as specified in the trial were met by our local population of patients.

While it is too early to assess whether local breast failure of our CMMC patients older than 70 years old and not irradiated matches the very good local control of the national trial, many physicians within the area were interested in how many patients who were offered Tamoxifen alone, actually received and remained on the treatment after their surgery, thereby giving an early indicator of possible increase of local breast failure.

From 2006, twenty five patients older than 70 years old with favorable breast cancer, less than 2cm and positive ER receptor status were offered observations on an anti-estrogen but without radiation. Of these, 13 initiated Tamoxifen, six Arimidex, and six Femara. To date, five of the original 25 have discontinued therapy, 20% overall. Two discontinued treatment due to leg cramps and edema, two because of fatigue, and one joint pain associated somewhat unusually with Tamoxifen. One patient switched from Tamoxifen to Femara due to a rash, but eventually discontinued Femara due to nausea.

This 20% failure rate to maintain anti-estrogen therapy, clearly is quite concerning, as it may lead to increased recurrence rates. While CMMC continues to offer eligible patients the possibility of observation without radiation, any increasing rise in patients not taking anti estrogen treatment may warrant a re-evaluation. Watch these pages for further follow up data.



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