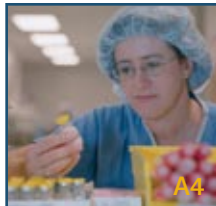


Central Maine Medical Center
**Physician
Update**



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ESOPHAGEAL CANCER MANAGEMENT AT CENTRAL MAINE MEDICAL CENTER



By Sally Van Snepson, M.S., P.A.-C., L.Ac., Hematology-Oncology Associates



Sally Van Snepson, M.S., P.A.-C., L.Ac.

Esophageal carcinoma is the ninth most common cancer around the world. According to the American Cancer Society, this disease is three to four times more common among men than among women and about 50 percent more common among African Americans than

among Caucasians. In the United States it is the seventh-leading cause of cancer-related deaths in men. Squamous cell carcinoma is the most common type of cancer of the esophagus among African Americans, while adenocarcinoma is more common in whites.

Cancer of the esophagus is much more common in some other countries than the United States. For example, esophageal cancer rates in Iran, northern China, India, and southern Africa are 10 to 100 times higher than in the United States. The main type in these countries is squamous cell carcinoma. In the United States squamous cell carcinoma has typically occurred more frequently among persons with significant alcohol and tobacco use histories. Squamous cell carcinoma begins in flat cells lining the esophagus while adenocarcinoma begins in cells that make and release mucus and other fluids.

According to the National Comprehensive Cancer Network (NCCN), there were 14,550 new cases of esophageal carcinoma and 13,770 deaths in the United States in 2006. The National Cancer Institute has estimated that in 2007 there will be 15,560 new cases and 13,940 deaths from esophageal cancer, fortunately not a significant increase from 2006.

Barrett's esophagitis and gastro-esophageal reflux disease (GERD) have been linked to the increased incidence of esophageal adenocarcinoma. Upwards of 30 percent of the western hemisphere's population is affected by GERD.

The initial workup and staging evaluation for esophageal cancer is based on the tumor/node/metastasis (TNM) classification developed by the American Joint Committee on Cancer (AJCC). NCCN guidelines recommend that newly diagnosed patients undergo a complete history, physical examination, and endoscopy of the entire upper GI tract. Histologic confirmation is required. Since 2006 [(18)F]fluorodeoxyglucose positron emission tomography has been included in the initial workup. Surgical pathology yields the most accurate staging.

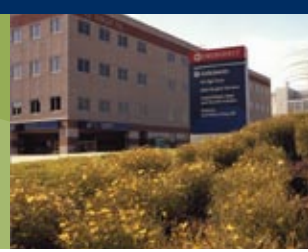
Unfortunately, most esophageal cancers do not cause symptoms until they have reached an advanced stage, when a cure is less likely. Most patients experience a combination of symptoms including weight loss, dysphagia, and pain. At diagnosis nearly 50 percent of patients have cancer that

extends beyond the locoregional confines of the primary. Stage I, II and III (locoregional cancer) are assumed to be potentially resectable, however fewer than 60 percent of patients can undergo a curative resection. Improvements in preoperative staging may result in improved prognostic stratification, improved patient selection for surgical therapy, and improved overall survival.

Primary therapy for medically fit patients, who are Stage I, II, III, and IVA (locoregional cancer) with resectable carcinoma, include three initial options:

- (1) partial or complete esophagectomy followed by further adjuvant therapy
- (2) Radiation therapy plus concurrent chemotherapy (5-FU-based) followed by partial or complete esophagectomy in certain settings
- (3) definitive chemotherapy/radiation therapy followed by observation/salvage surgery (approximately 20 percent of cases at a median of 18 months)

Response rates to Cisplatin and 5-FU range from 20 percent to 50 percent, therefore combined modality treatment is the subject of much investigational effort. Those with obvious metastatic carcinoma (stage IVB) are stratified into treatment groups based on Eastern Cooperative Oncology Group performance scores into either salvage chemotherapy or best supportive care.



From 2001 to 2006 there were 122 patients diagnosed and/or treated at Central Maine Medical Center for esophageal cancer. This total included 97 males and 25 females, all Caucasian except for one patient. Their ages ranged from one patient diagnosed in their thirties to two patients diagnosed in their nineties. All but 15 patients had a current or previous smoking habit.

The most common site of esophageal cancer involved the lower third/GE junction of the esophagus and was seen in 96 patients. Adenocarcinoma arising from the GE junction usually involves both distal third of the esophagus and proximal stomach. The second most common site involved the middle third of the esophagus and was discovered in 11 patients.

Adenocarcinoma was the most common histology for CMMC's patients. There were 92 patients with a form of adenocarcinoma, 21 patients had squamous cell carcinoma, and nine patients had non-specific epithelial carcinoma. The AJCC staging manual does make mention that the histologic type of cancer is not a prognostic factor.

Geographically, Androscoggin County was the area with the most patients, followed by Oxford, Cumberland, Franklin and Kennebec counties. The variety of counties reflects the Central Maine Health-care hospital family that extends to Bridgton Hospital in Cumberland County, Rumford Hospital in Oxford

County and Franklin Memorial Hospital's Outpatient Oncology Clinic in Franklin County.

Treatment at CMMC from 2001 to 2006 showed that radiation and chemotherapy accounted for the primary treatment in 34 percent of the cases. The combination of surgery, radiation and chemotherapy was completed in 30 percent of the 122 patients diagnosed. Patients who had no treatment, palliative radiation or surgery alone accounted for 7 percent each.

Over the five-year study 7 percent of the patients were classified as Stage I with a survival rate of 63 percent. Stage II patients comprised 37 percent of all patients with a survival rate of 33 percent. Stage III accounted for 19 percent of patients with a survival rate of 35 percent and Stage IV patients equaled 24 percent of the whole with a survival rate of only 10 percent. Patients not staged had a 13-percent survival rate.

Overall, 33 patients (of the 122 total) survived five years from the initial diagnosis, a 27-percent survival rate. The National 5-Year Relative Survival Rates from the Surveillance Epidemiology and End Results website reveals that the average survival rate for all stages of esophageal cancer is 15.6 percent. Much of the improvement in CMMC's overall survival rate reflects an unexpectedly high five-year survival of Stage III patients.

Post survival recommendations from the NCCN are for systematic follow-up for all patients regard-

less of clinical stage. Asymptomatic patients should undergo a complete history and physical examination every four months for one year, then every six months for two years, and then annually thereafter. Unfortunately, diagnosis is often made late, limiting therapeutic approaches. However, palliative measures continue to improve and new chemotherapeutic agents are being researched and used in clinical studies.

References:

Journal Watch Oncology and Hematology

Surveillance, Epidemiology & End Results

National Cancer Institute

National Comprehensive Cancer Network

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PRESCRIPTION DRUG MONITORING THROUGH THE MAINE OFFICE OF SUBSTANCE ABUSE

By Lynda D. Benak, Daniel Eccher, Roy E. McKinney, and Craig M. Smith

Poverty and the desire for a better place in society affect people in different ways. Many choose an earnest path of hard work, consistency, and hope, while others choose drug diversion and the illegal movement of prescription medications for cash. No doubt, it's a quick financial infusion for many, but at what cost to themselves and others?

Drug diversion and sale of prescription medications is a risk to the community health care system's reputation and, ultimately, to public health. Physicians make reasonable efforts to diagnosis a patient circumstance based on patient presentation, history, evaluation, prior treatment, and finally, input information from other providers. The bottom line is that medicine is a very human science, where sometimes, mistakes are made. Physicians/providers are responsible for writing prescriptions, and ultimately, it is their action or inaction that may be challenged.

Daniel Eccher, M.P.H., B.A., Project Coordinator of Maine's Prescription Monitoring Program (PMP), Maine Office of Substance Abuse, has been providing valuable education throughout our hospital system and the state, in an effort to get 100 percent of practicing providers registered to use the PMP, their support of this important initiative is essential.

RISK MANAGEMENT PERSPECTIVE

As a role responsibility in a regional health care system, risk management was asked to provide legal education and support to one of its physicians. His license had been called into question by a new patient, through a written complaint to the state Board of Medicine, as the physician would not provide the patient with the prescription medications he was requesting for ongoing conditions during the first office encounter.

One of our physicians, who is an excellent clinician familiar with the state resources available, had already obtained a log-in to Maine's PMP. He was able to trace the patient's prescription activity based on a report generated by the PMP; interestingly, the patient had been receiving prescriptions from multiple physicians, from different practices, and from multiple pharmacies in Maine. The physician confronted the patient with this information and explained that the information was available to all physicians throughout the state.

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Usually, this is a simple matter requiring the physician to respond in writing to the medical board, outlining the circumstances of the patient's care and treatment, including why prescriptions may have been denied.

This situation had a different twist however; as the physician's deposition was requested by a state detective who was contracted by the Board of Medicine to further investigate the complaint. This was unfamiliar to us, and required corporate counsel and risk management to represent our physician prior to and during deposition.

The patient denied the findings. In an effort to help the patient, the physician offered a temporary prescription for pain with the understanding that the patient would follow up with a designated pain specialist within the system. He explained to the patient that he would no longer prescribe medications just for "pain management."

Other red flags in this case included hand-carried medical records from multiple states, multiple physicians used by the patient in several states, and inconsistencies in the patient's history and timeline in different offices.



Most physician practices can describe situations like this one in which a patient's demand for prescription medications has put them in a difficult position. Even though patients may think they are quite appropriate, those addicted to prescription medicines pose a challenge to the overall system, as they are often demanding, impatient, manipulative, and threatening, all of which have an impact on the effectiveness and safety to our staff as well as the daily flow of patient care.

Telephone triage calls often become heated and disturbing when patients become threatening on the phone, to the point where staff members are placed on alert for a possible on-site concern. To accommodate patients who are known to have addiction issues with prescription medications, medication agreements (contracts) are obtained that specifically outline the expectations from both patient and provider, and the consequences for violation of the agreement. Sometimes, after warning letters have been sent and the patient has been counseled, patients leave the practice no alternative but to discharge them. If the behavior is disturbing enough, discharge from the health care system is necessary. This is a difficult decision and not taken lightly, as our primary business focus is patient care. The decision to discharge a patient is often made after he or she has been transferred to several in-system practices, with ongoing concerns for noncompliance, difficult behavior, and violation of medication agreements.



The increasing expectation on physicians' time continues to be a concern for all health care systems and is an important issue that requires sensitivity. However, given the useful information that PMPs might provide in diagnosis and treatment of patients, we might forecast that knowledgeable integration of this tool decreases time spent in deliberating prescription medications.

The next installment in this series will explore the care provider's perspective in dealing with drug diversion and addiction issues in their patient population.

Author Biographies:

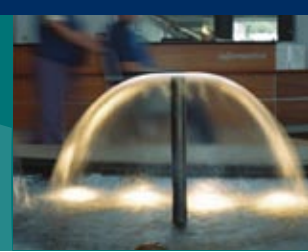
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PLASTIC SURGEON'S STUDY CONFIRMS THAT TISSUE TRANSFER PROCEDURES ARE SAFE IN COMMUNITY HOSPITALS



A plastic surgeon from Central Maine Medical Center has presented to a national surgical organization the results of a study confirming that tissue transfer procedures, once performed only at major medical centers, are now safely done in community hospitals.

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Steven C. Bonawitz, M.D., of Central Maine Plastic Surgery, a clinical department of Central Maine Medical Center, presented a paper entitled "Free Tissue Transfer In Private Practice: Experience With 100 Patients" at the annual meeting of the American Society of Plastic Surgeons held recently in Baltimore.

The study reviewed his work in performing microsurgical tissue reconstruction using skin taken from "donor sites" on the patient's own body. The technique has many applications including breast reconstruction following mastectomy, closure of wounds in trauma patients, and management of chronic wounds resistant to other treatments. All the 100 patients and 107 procedures were done in local medical centers.

In the study, Dr. Bonawitz explained that tissue transfers, once performed only by microsurgical teams in major medical centers, are now safely be done in community medical centers. This change has been aided by the development of improved technology, including magnification, imaging technology and better instruments and suture materials.

Over an eight-year period, Dr. Bonawitz's research demonstrated that 97 percent of the tissue transfers were ultimately successful, with overall complication rates comparable to national averages. Post-procedure infections and bleeding problems were less than national averages.

"The study demonstrated that free tissue transfer can be undertaken in the private practice setting with results that compare favorably with those achieved in major tertiary medical centers. Free tissue transfer is the procedure of choice in many reconstructive situations due to its reliability and versatility, and the technique can be safely offered to patients in the private practice setting by surgeons who are trained in and comfortable with free tissue transfer techniques," Dr. Bonawitz said.

A member of the Lewiston-Auburn medical community since 1994, Dr. Bonawitz completed a fellowship in craniofacial surgery with

the Department of Plastic Surgery at Medical College of Wisconsin in Milwaukee.

A Phi Beta Kappa graduate of the State University of New York in Albany, N.Y., he was awarded his medical degree from the State University of New York Health Science Center at Syracuse College of Medicine in Syracuse, N.Y. He served a general surgery residency with The Western Pennsylvania Hospital in Pittsburgh, where he was presented the Dunmire Award for being the Outstanding Surgery Resident. He completed a two-year plastic surgery residency with the University of Rochester



Steven C. Bonawitz, M.D.

Medical Center Department of Plastic Surgery in Rochester, N.Y.

Dr. Bonawitz is certified by the American Board of Plastic Surgery.

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