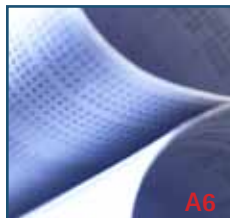
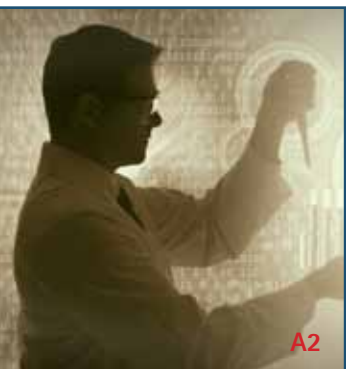


*Central Maine Medical Center*

# Physician Update



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# CENTRAL MAINE MEDICAL CENTER STUDY SHOWS MELANOMA INCIDENCE RISING DRAMATICALLY

BY TRUDI CHASE, M.D.



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**The incidence of melanoma in the United States continues to increase dramatically. In 2000 it was estimated that one in 90 Americans would develop melanoma. In 2005 that estimate had increased to one in 55. During this time the treatment of melanoma has changed very little.**

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Surgery continues to be the primary treatment for local and regional melanoma. Sentinel node biopsy is encouraged for all lesions greater than or equal to 1 mm deep and is considered for all lesions less than 1 mm deep with adverse features. Sentinel node biopsy remains an important staging tool, but its impact on survival is unclear. Interferon remains the only off-protocol adjuvant treatment, but it is somewhat controversial. The current National Comprehensive Cancer Network (NCCN) guidelines give adjuvant interferon a 2B rating, defined as "based on lower level evidence and there is no uniform NCCN consensus (but no major disagreement)." For metastatic disease, the only new drug is Temodar and it remains somewhat controversial. NCCN guidelines give Temodar, and any chemotherapeutic or biologic therapeutic modality for metastatic melanoma, a 2B recommendation.

## **STUDY OF MELANOMA AT CENTRAL MAINE MEDICAL CENTER: STAGING**

Between 1999 and 2009 there were 179 melanoma cases identified at CMMC. This compares to 114 cases identified in the 12-year period from 1986 to 1998.

The first notable difference between the two CMMC studies is that more melanomas are being diagnosed currently. The increase could be explained by the increasing incidence of melanoma, but there are other possible explanations: an increase in the local population and better detection. Another explanation for the growth in total numbers is that the CMMC Cancer Registry may be collecting cases from a wider geographic area as the hospital increasingly serves as a tertiary referral center. The rising use of sentinel node biopsy may be contributing to increased referral rates.

The percentage of Stage 0 CMMC patients has gone from 7 percent to 16 percent, comparing favorably with recent national numbers. This increase may reflect increasing incidence or better detection. The

incidence of Stage I melanoma is similar in both CMMC studies. This similarity suggests that the moving of T2b N0 M0 cases from Stage I to Stage II has not had a significant impact on the distribution of stages at diagnosis. Stage II CMMC data, at 25 percent historically and 19 percent currently, seems to indicate more cases of Stage II disease than the recent national average of 11.4 percent. This discrepancy is not easily explained. The addition of T2b N0 M0 disease and T4 N0 M0 disease to Stage II would suggest an increase in the percentage of Stage II cases over time, but this has not happened. Perhaps the increasing use of sentinel node biopsy has offset the anticipated increase in Stage II cases as it has been estimated that 5 percent to 30 percent of Stage I and II cases are upstaged to Stage III by that procedure. However, the percentage of Stage III cases at CMMC has only changed from 17 percent historically to 18 percent currently. CMMC numbers remain higher than recent national percentage of 6.5 percent. The percentage of Stage IV disease remains low, although the historical local number of 7 percent is higher than the current percentage of 3.3 percent and the national percentage of 3.6 percent.



CMMC does very well in getting patients staged. The historical percentage of 2.5 percent and the current percentage of 3.9 of unstaged cases are much lower than the national unstaged cases percentage of 14.5. The increased number of CMMC staged cases may explain the difference in distribution of cases of Stage II and Stage III at diagnosis.

### **STUDY OF MELANOMA AT CENTRAL MAINE MEDICAL CENTER: SURVIVAL RATES**

Survival has not improved for Stage IV disease at CMMC, confirming that metastatic melanoma treatment remains dismal. Survival for Stage III disease seems to have improved at CMMC and the change in staging does not seem to explain this. Patients with pT2b disease have been moved from Stage III to Stage II. Theoretically this change would have resulted in worse survival rates as a better prognostic group was removed from this category. The increasing use of sentinel node biopsy may explain this phenomenon. Between 5 percent and 30 percent of patients are upstaged by sentinel node biopsy from clinical Stage I to pathologic Stage III. These patients may now be included in the Stage III data but may have a better prognosis even without further treatment, thus shifting the survival rates. Another explanation is that Stage III patients may be getting



more treatment after diagnosis with adjuvant interferon. This explanation suggests that sentinel node biopsy has impacted overall survival, even though this has not been demonstrated through national trials. Current Stage II survival rates are about the same as historical rates or possibly slightly improved. There have been two staging changes since the 2002 reclassification that could affect Stage II cases. Stage II now includes T4b N0 M0 patients from Stage III and the T2b N0M0 patients from Stage I. This suggests that one patient population would improve the survival rate and one patient population would negatively affect survival. The Stage I survival curves appear to be much the same for all populations and remain quite good. Again, with the staging reclassification, one would expect the Stage I survival curve to improve over time with the removal of the T2b N0 M0 patient's from Stage I to Stage II.

However, the survival rates are so good that a small difference may not be detectable. The Stage I rates are very good and almost identical to the Stage 0 cases.

**Trudi Chase, M.D., practices with Hematology-Oncology Associates, a clinical department of Central Maine Medical Center, in Lewiston, Maine.**

# CENTRAL MAINE COMPREHENSIVE CANCER CENTER POISED TO OFFER EXPANDED TREATMENT OPTIONS



BY LOUISE I. MARCOTTE, M.S.S.

**Providing patient access to nationwide clinical trials has long been an important component of the Central Maine Comprehensive Cancer Center at Central Maine Medical Center in Lewiston, Maine. And with recent developments in its oncology physician staff and clinical research program, CMMC is poised to offer expanded treatment options to Maine oncology patients.**

Clinical trials are designed to answer questions not only concerning the diagnosis and treatment of cancer, but about prevention and symptom management as well. Oncology clinical trials offer an avenue of treatment not available to cancer patients via the current standard of care. All clinical trials at CMMC must gain approval from the Institutional Review Board (IRB), a group that meets regularly to review the safety of clinical trial protocols. The IRB's mission is to protect the rights and welfare of human research participants.

Access to the National Cancer Institute's (NCI) Clinical Trials Support Unit is provided through CMMC's affiliation with the Radiation Therapy Oncology Group at Dartmouth-Hitchcock Medical Center in Lebanon, N.H. Through this affiliation, selected studies from many nationwide cooperatives like Eastern Oncology Group, Southwest Oncology Group, and International Breast Cancer Study Group are open to Maine patients.

CMMC in 2008 became an affiliate of the Sarah Cannon Research Institute in Nashville, Tenn., a non-profit

organization that provides access to pharmaceutical studies not previously available to CMMC cancer care providers and their patients.

Pharmaceutical studies tend to be more labor intensive than NCI cooperative group studies due to sponsor requirements for ancillary activities. Their timeline for completion of contracts and budgets often is quite aggressive. With the addition of a senior clinical research coordinator, CMMC is in a better position

to conduct pharmaceutical trials, including treatment options not available through the cooperative group studies.

In 2006 new diagnoses of lung cancer surpassed the number of new diagnoses of breast cancer for the first time in the history of CMMC's cancer program. With its selection as a site for the International Early Lung Cancer Action Program (I-ELCAP), a program of Cornell University's Weill Medical College, CMMC joined a group of 48 institutions in nine countries dedicated to studying the benefits and best practices of early detection of lung cancer by CT screening. CMMC is the only northern New England institution participating in I-ELCAP. Participation in the program allows CMMC to offer thousands of Maine residents local access to cancer care that could save lives.

**Louise I. Marcotte, M.S.S., is director of clinical research at Central Maine Medical Center**



# EFFORTS TO REFINE CANCER DATA COLLECTION STANDARDS WILL YIELD MORE ACCURATE CODING



BY SUE MANDELL, M.D.



National cancer data collection standards are being refined and revised as part of an effort led by the Commission on Cancer (CoC) to develop more accurate coding of patient diagnosis, treatment and outcomes.

The CoC has recommended all cancer diagnoses have both clinical and pathologic staging when appropriate. These new standards recommend that each diagnosis be processed through a collaborative staging scheme consisting of 15 data fields designed to derive Tumor, Node, Metastasis (TNM) and Stage Group as established by the American Joint Committee on Cancer (AJCC) Staging Manual. At the Central Maine Comprehensive Cancer Center (CMCCC) in Lewiston, Maine, a sample of cases is reviewed and approved by physicians as part of the hospital's quality assurance program.

Specific details regarding curative versus palliative treatments, including doses of radiation, chemotherapy agents used, and even the use of embolization in treatment, are gathered. By improving reporting standards and information on outcome data, researchers believe their work will better inform clinicians regarding overall patient care.

CMCCC's Cancer Registry collects cancer data for both diagnosis and treatment at CMMC as well as follow-up. The top three diagnoses at CMMC continue to be breast, lung and prostate, with colorectal and non-Hodgkin's lymphoma rounding out the top five.

Breast and lung cancer incidence is slightly higher compared to national averages; 20 percent to 13 percent for breast cancer, and 19 percent to 15 percent for lung cancer, respectively. The diagnosis of non-Hodgkin lymphoma has increased by over 50 percent from 15 analytical cases in 2007 to 36 in 2008, making the incidence of the disease comparable with national statistics.

CMCCC was reviewed by the Commission on Cancer in 2007 and awarded three-year accreditation as a Community Hospital Comprehensive Cancer Center with commendations – the highest level of accreditation granted to community hospitals.

Among other things, the program was commended for the timeliness of abstracting data, the quality



of data submitted, 100 percent compliance with AJCC staging, 93 percent compliance with quality assurance review and monitoring of National Comprehensive Cancer Network guidelines, active outreach programs, and registrar educational and quality improvement activities.

Sue Mandell, M.D., is a radiation oncologist who practices at the Cynthia A. Rydholm Cancer Treatment Center, a component of the Central Maine Comprehensive Cancer Center.

# “OPEN ACCESS” PATIENT SCHEDULE REDUCES NO SHOW RATES AND IMPROVES CUSTOMER SERVICE SCORES



**A new patient scheduling system that stresses flexibility has reduced patient “no show” rates, improved customer service, and increased patient billings, according to one of the system’s architects.**

Reginald Albert, director of specialty practices for the Central Maine Medical Group, Central Maine Medical Center’s multi-specialty group practice, says a recently-implemented “open access” patient schedule system usually provides same-day appointments, but guarantees a patient an appointment within 72 hours for whatever need they may have.

“We have found that the success of this new program – shown in significantly reduced no show rates, improved customer service scores and increased patient billings – has only come with a lot of pre-planning and patience. If anyone tells you that you can quickly implement an open access model of scheduling, challenge them, as it may be doomed to failure. It is essential that you have a plan in place, that you monitor your progress, and be open to making changes along the way. This is not a one-size-fits-all model; creativity and quick thinking are a must,” Albert says.

The Central Maine Medical Center Family Medicine Residency began implementing open access scheduling methodology nearly two years ago by reorganizing its clinical practice into five teams. Each of the teams is supported by at least one faculty, one first-, second- and

third-year resident, and one clinical and one clerical support person.

Albert said the practice assures patients when they make an appointment that they will see either their primary care provider or a member of their provider team. This has contributed to patients being more satisfied with the service they receive and has significantly improved overall continuity of care within the practice.

“We slowly transitioned all of our appointments to 20 minutes each, worked down our backlog of previously scheduled appointments, and made a conscious decision to only pre-book 40 percent of our appointments,” Albert says. “We found that in doing this, we

satisfied the patients who insisted on having a pre-booked appointment and those providers that wanted to insure something was scheduled.”

Under the new system, a patient calling the CMMC Family Medicine Residency now gets an appointment within a maximum of 72 hours, and usually a briefer period of time, whether the need is follow-up care, a physical exam, well child check, or other non-urgent visit.

“The cooperation of faculty, residents, clinical staff, and especially a strong front desk staff has been essential to our success. A lot of education is needed for both patients and staff, and they both should be included along the way throughout the whole process. We now look forward to moving this model to several more of our primary care offices,” Albert said.

**For more information about open access scheduling, call Reginald Albert at 207-795-2811.**





# THE DEMPSEY CHALLENGE

A JOURNEY FOR HOPE



Sunday,  
October 4  
Lewiston/Auburn



## Cycle, run or walk to benefit The Patrick Dempsey Center for Cancer Hope & Healing

- » **Cycle, Run or Walk!**  
Events include 100, 50, 25 and 10 mile cycling tours, 5K Run/Walk and Kids' Fun Run
- » **Festival in the Park**  
Health and Wellness Expo, KidZone, live entertainment and survivor walk
- » **Special Incentive**  
Raise \$10,000 and participate in a private ride with actor Patrick Dempsey and pro cyclist George Hincapie and others!
- » **Fundraising**  
Various incentives available, but fundraising not required for participation