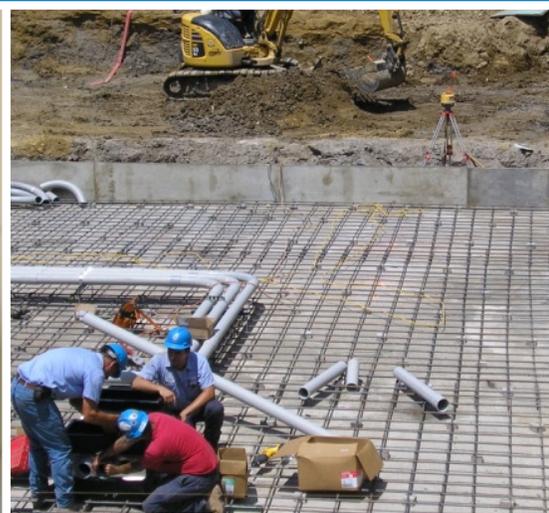


UVMC Cancer Care Center Annual Report

2010 Program Update (2009 Statistical Review)





Cancer Care Center Mission Statement:

Our mission is to provide leadership and a comprehensive continuum of cancer services to our patients and their families, focusing on education, prevention, early detection, and management of cancer.

Cancer Program Description:

Upper Valley Medical Center's Cancer Program is approved by the American College of Surgeons Commission on Cancer and the Joint Commission and is committed to the Commission's Standards of Performance Improvement, outcome measurements, cost-effectiveness, and collaboration with physicians and other health care service agencies. Our patient-centered model of care enables us to practice in a comprehensive manner and recognizes the impact cancer has on the lives of individuals and their families.

About Upper Valley Medical Center and Premier Health Partners:

Upper Valley Medical Center (UVMC) is a not-for-profit health care provider committed to serving the health care needs of Miami County, Ohio and the surrounding area. Comprehensive inpatient and outpatient services are provided with a full complement of diagnostic and treatment services and behavioral health care programs. Visit online at www.uvmc.com.

UVMC is part of Premier Health Partners (PHP), a health system whose 14,000 employees serve southwest Ohio through member hospitals and affiliate organizations in seven counties. PHP is dedicated to improving the quality of health by enhancing access to health services, expertise, and information at every stage of life. Visit online at www.premierhealthpartners.org

Friends and Colleagues

This annual report presents a summary of Upper Valley Medical Center's (UVMC) Cancer Care Program activities and statistical data for the year 2009.

UVMC's cancer program is a Community Hospital Cancer Program as designated by the American College of Surgeons (ACoS) Commission on Cancer (CoC). The program underwent re-accreditation in 2008 by the CoC as part of the approvals process, which requires team work and collaboration between all aspects of the cancer program. We were approved with commendation for three years and received excellent feedback from our surveyor. This approval ensures patients that they will have access to the full scope of services required to diagnose, treat, rehabilitate, and support patients with cancer and their families.

Enclosed in this annual report are the following:

- Bone Health in Cancer
- Prognostic and Predictive Markers in Breast Cancer
- Focus Site Study on Melanoma
- Lynch Syndrome
(HNPCC Hereditary Nonpolyposis Colorectal Cancer)
- Cancer Survivor Stories

Please feel free to contact me or the Cancer Care Center at (937) 440-4820 if you have any questions.

Sincerely,

L. Stewart Lowry, MD, FACS
Medical Director, Cancer Care Center
ACoS CoC Cancer Liaison Physician



L. Stewart Lowry, MD, FACS

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Upper Valley Medical Center's 2010 Cancer Committee

Cancer Committee Chairperson

Mohan Nuthakki, MD, Medical Oncology /
Hematology

Cancer Physician Liaison

L. Stewart Lowry, MD, FACS, General Surgery

Physician Members

Fayez D. Abboud, MD (Ad Hoc)
Gastroenterology

Craig Critchley, DO
Family Practice

Barbara Evert, MD
Vice President/Chief Medical Officer

James B. Frost, MD
Radiology

B. Mark Hess, MD
Internal Medicine

Belayet Hussain, MD
Urology

Carlos Machicao, MD
Pathology

Tom J. Nickras, MD
Internal Medicine

Ronald Setzkorn, MD
Radiation Oncology

Program Activity Coordinators

Cancer Conferences
Misty Frank

Community Outreach
Jean Heath

Community Outreach
Sarah Jones

Registry Quality Assurance
Jodi Long

Clinical Trials
Robin Holcomb

Non-Physician Members

Diane Birchfield, RDLD
Nutrition Services

Debbie Coons, LSW
Social Work

Robin Holcomb, RN, BSN, OCN
Clinical Trials

Jill Demmitt, RN
Hospice

Jean Heath, RN, BSN, MA, OCN
Director, Cancer Care Center

Linda Irvin
Physical/Occupational Therapy

Sarah Jones, RN, MS, AOCNS, CRNI, ACNS-BC
Oncology Clinical Nurse Specialist

Stephanie Kaiser, RN
Nursing

Jodi Long, RHIT
Oncology Research Analyst

Misty Frank
Assistant Oncology Research Analyst

Sandi O'Neal, RT(T)
Radiation Therapy

Becky Rice, MA, FACHE
Vice President, Patient Services

Robin Supinger
American Cancer Society

Julie Wheeler, RN
Enterostomal Nursing

Lora Wilcher, RN, BA, MSN
Palliative Care

Thomas Zaugg, R. Ph.
Pharmacy

2010 Goals and Accomplishments

Programmatic and Clinical Goals

- Participation in the American College of Surgeons Commission on Cancer national study understanding Variations in Surgical Outcomes of Surgery.
- At least 85% of breast cancer patients under 50 years of age with at least 1 red flag for the BRCA 1 or 2 mutations will be referred for genetic testing.
- To increase cancer awareness in the community-at-large by participating in at least 10 outreach events this year.
- UVMC continues to accrue patients into clinical trials and monitor them effectively through Robin Holcomb, the Clinical Trials Coordinator.
- Sarah Jones – Cancer Committee identified Febrile Neutropenia as a high risk problem, and methods were identified to capture febrile neutropenia data to quantify the problem.
- Genetic testing counseling has been made available at UVMC through Sarah Jones and is ongoing with referrals and tests.

Accomplishments

- Yearly Oncology Nursing Competency was given to the UVMC Oncology Nursing staff.
- Short term study Melanoma by Dr. L. Stewart Lowry, MD, FACS was reported to the Cancer Committee.
- Cancer Registry software upgrade from MRS to Metriq was completed.

UVMC Cancer Program Community Outreach Events

- Annual Relay for Life held at the Miami County Fairgrounds.
- John J. Dugan Cancer Awareness Foundation Event.
- Bill and Ruth McGraw Cancer Awareness Symposium with featured guest speaker Bruce Feiler, New York Times best selling author of 10 books including “Walking the Bible,” “Abraham,” “America’s Prophet” and “The Council of Dads: My Illness and the Men Who Could Be Me”.
- Go Red For Women/North held at Edison Community College.
- The Chris Cianciolo - Edison 5K for Cancer.
- UVMC Cancer Care hosted prostate and colorectal cancer screenings.
- Look Good... Feel Better events held throughout the year at UVMC. These events are sponsored by The Cosmetic, Toiletry and Fragrance Association, The National Cosmetology Association, and The American Cancer Society.
- Jean Heath made a presentation and spoke to the Troy Business Women’s Club about breast cancer.
- Various other outreach programs were presented throughout the community emphasizing early detection, breast cancer screenings, nutrition, and genetic testing for cancers.



“I have heard there are troubles
of more than one kind. Some come from ahead
and some come from behind. But I’ve brought a
big bat. I’m all ready you see. Now my troubles
are going to have troubles with me!”

- Dr. Seuss

The Cancer Care Center at Upper Valley Medical Center

The UVMC Cancer Care Center

The Cancer Care Program is a Community Hospital Cancer Program as designated by the American College of Surgeons (ACoS) Commission on Cancer (CoC) and provides the full spectrum of oncology patient and community services including radiation, medical and surgical oncology as well as research via the Dayton Clinical Oncology Program. We offer High Dose Rate (HDR) Brachytherapy treatments including breast, prostate, cervical and skin, as well as Intensity Modulated Radiation Treatments (IMRT).

Cancer Care Center Expansion Project

Our Infusion Clinic provides treatment for many additional medical and surgical conditions including management of symptoms and side effects along with placement of intravenous access devices.

Through local support from the John Dugan Memorial Foundation, and the Bill and Ruth McGraw Memorial Fund we have been able to enhance our long term services, such as our heat and massage infusion chairs and our dedicated CT scanner, but have outgrown our current facility. The majority of our population, including Miami, Shelby, and Darke counties, need conveniently

located, accessible care. We feel this is a very high priority for our patients. That is why we have started construction on an additional vault and linear accelerator (LINAC) allowing for uninterrupted service to our patients.

In addition, we are currently planning the construction of a 12,750-square-foot Cancer Care Center at ground level over the next 18 to 24 months, in order to provide ongoing comprehensive cancer care close to home.



Jean Heath, RN, BSN, MA, OCN
Director, Cancer Care Center



Cancer Care Center Front Desk Staff:
Bonnie Brown, Receptionist, and Brenda Thornton,
Office Coordinator



Construction begins on the new linear accelerator vault.

Radiation Oncology

Another year has turned and we are constantly working on ways to better the cancer patient's experience here at UVMC in the Cancer Care Center. This now includes the ongoing expansion of our Cancer Care Center, which will include a new, second linear accelerator in 2011.

We became the 13th cancer center in the United States to offer skin cancer treatments with the newest techniques and equipment for High Dose Rate (HDR) Brachytherapy. This has dramatically improved the accuracy of treatments to the skin and reduced the inconvenience of care on the patient with fewer visits.

We continue to offer intensity modulated radiation therapy (IMRT) with image guided radiation therapy (IGRT) to the appropriate patients, which brings with it the ability to target an area of cancer specifically within 1 to 2 mm of daily accuracy. We maintain a dedicated computerized tomography (CT) scanner in the department to plan and monitor patient care. This improves the cancer patient's experience here in the Cancer Care Center.

We continue to offer the option of HDR prostate temporary implantation, which carries a number of advantages over other forms of prostate cancer management. Working closely with our urologists on staff, we can consider this type of therapy individually for each patient.

While these events unfold, we try never to lose sight of the goals of helping patients to understand their disease and their options for care, and helping them in any way possible. Our "team" remains truly exceptional in that regard. We strive to keep in touch with each and every member of our patient family.



Ronald Setzkorn, MD
Radiation Oncology



Cancer Care Center Staff (L-R) Back Row: Bill, Dr. Setzkorn, Brianne, Sandi. Front: Suzanne, Jodi, Karmyn, Kim



Cancer Care Center Staff (L-R) Top: Ginny, Dr. Setzkorn, Sarah, Kristy. Bottom: Tracy, Kari



Sandi O'Neal RT(T)
Chief Therapist

Radiation Therapy

The Upper Valley Medical Center's Cancer Care Center currently has five full-time Registered Radiologic Therapists. They are certified by the American Registry of Radiological Technologists and licensed by the Ohio Department of Health. The staff of the Cancer Care Center is dedicated to the continuous improvement of the department.

The Cancer Care Center has started a new program using the Leipzig applicators. These applicators allow us to treat skin lesions using the HDR (High Dose Rate) Brachytherapy Machine. By using these applicators, we are able to treat the patient in six to 10 treatments rather than the traditional 25-30 treatments. This is considerably easier on our older patients who may have problems with transportation or do not ambulate well. By using the Leipzig Skin Applicators we also are able to reduce the amount of healthy tissue being treated.

My duties as Chief Therapist in the Cancer Care Center are to oversee the daily running of the Radiation Therapy side of the department. I am responsible for all the billing, scheduling of therapists, Diode Q.A., call schedules, daily treatment log, annual calibration of equipment, machine maintenance, Patient Safety Officer, Clinical Advisor for Raymond Walters and Washburn Students, and serve on the Radiation Safety Committee.



Cancer Care Center Radiation Therapy Staff
(left to right) back: Sandi, Karmyn; front: Brianne,
Kim, Jodi



“The only disability in life
is a bad attitude.”

- Scott Hamilton

Medical Oncology/Hematology

Bone Health in Cancer

Treatments for cancer have significant effects on bones. In premenopausal women, chemotherapy leads to early menopause, accelerating bone loss. In postmenopausal women with breast cancer and in men with prostate cancer, the hormone supplementary therapy can enhance osteoporosis. Bone metastasis is common in many cancers and leads to bone pain, fractures, immobility and blood clots.

Bone health is evaluated by bone mineral density (BMD). The World Health Organization (WHO) developed a risk assessment tool (FRAX), combining BMD with other risk factors for fracture, including age, to provide estimates of 10 year risk for fracture. Medicare guidelines recommend treatment for patients with 10-year FRAX risk of 3% for hip fracture and greater than 20% for all major fractures.

Initial strategies for prevention and treatment of bone loss include lifestyle modifications such as weight bearing strength training and balance exercises, smoking cessation and limiting alcohol intake, fall prevention and calcium supplements (at least 1200 mgs daily) and vitamin D (800 - 1000 IU daily). Medications are strongly advised for people with T-score below -2. Estrogen replacement therapy, Raloxifene and terapatide (recombinant parathyroid hormone) are generally used for non-cancer patients. Pamidronate (Aredia) and Zoledronic (Zometa) are used for treatment of bone lesions in cancer patients for pain control and prevention of fractures.

Emerging evidence suggests that these bisphosphonates may have antitumor and antimetastatic properties in breast cancer patients. Oral clodronate combined with chemotherapy for recurrence prevention in early stage breast cancer patients showed promising results. Zoledronic acid (ZA) showed decrease in recurrence in early stage breast cancer patients when combined with endocrine therapy (ABSCG - 12 trial). In Z-FAST and ZO- FAST trials, ZA plus letrozole, up front showed significant benefit compared with ZA given in later years of treatment. Several other studies are ongoing to study this benefit. Denosumab is another promising agent in delaying SRE (skeletal related events).

For bone metastasis- localized therapies, such as radiation and surgery, offer palliation and prevention of impending fracture or cord or nerve compression. Radiation therapy provides response rates of 60% to 70% and complete pain relief in 20% to 30% of patients. Surgery can provide pain relief, provide stabilization and prevent impending fracture or cord compression in lytic lesions that are greater than 2.5 cm or encompass more than 50% of the bone diameter or avulsion of lesser tolerated lesions, or involvement of weight-bearing bones.

Comprehensive approach for bone health in cancer patients includes a multi-disciplinary approach, including systemic anti-cancer therapy, bisphosphonates, analgesics, surgery and radiation therapy, on a case by case basis.



Mohan Nuthakki, MD

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Jim and Connie Schiff

After suffering three strokes and losing a leg to amputation, the last thing Jim Schiff needed was a cancer diagnosis.

But, that's exactly what happened in 2009.

Schiff and his wife, Connie, faced the lung cancer diagnosis and treatments with a positive attitude, the same way they'd faced other challenges in their 55 years of marriage.

"People say, 'You've got a great attitude,' but this is the way it is," Jim said. "I tell my kids I am too old to cry. You've got to look at it and say, 'Let's go, let's do it.'"

The Sidney natives were no strangers to cancer – Connie lost an eye to a melanoma in the 1970s – but cancer wasn't on their minds last spring and summer after Jim fell ill.

Beginning in April and continuing into September, Jim had seven surgeries, three strokes and lost a leg after surgeries failed to save it. During one of the surgeries, doctors told the couple Jim had lung cancer in the mediastinum.

Although treatment was proposed at a Lima hospital, the Schiffs wanted to be closer to home. They turned to UVMC Cancer Care Center. Jim had spent time in the UVMC rehabilitation unit following his leg surgery.

"The people there are just unbelievable. We've never had such good treatment. I can't say it's a pleasure down there, but ...," Jim said of his experiences at the Cancer Care Center.

Despite under going 34 radiation treatments and 15 chemotherapy sessions, Jim never fell ill from the treatments. The week of Christmas a full body scan showed no cancer.

Keys in their cancer journey with Jim were his prior experience with bladder cancer around five years ago and Connie's knowledge from years in nursing and her experience battling cancer as a young mother in the 1970s.

"Knowing she's there, still survives, I think has helped me," Jim said.

He recalled how he was advised to get the affairs of his young family in order as doctors contemplated Connie's treatment. At the time, the family included four children under age 6.

Support of family, friends and strangers also has been vital. "We have been just amazed at the support, the prayers that we have received," Jim said. "I don't think there was a church in Sidney that our name wasn't on the prayer list."

ADVICE from Jim and Connie Schiff

- Remain positive.
 - Have faith.
 - Have people around you who care.
 - Have confidence in caretakers at hospital and at home.
 - Ask questions.
-

A sense of humor also has helped, as evidenced by the Schiffs teasing of each other as they discussed the ups and downs of their journeys through cancer.

Connie said she wasn't shy about asking questions of health care workers throughout Jim's hospitalization, surgeries and treatment.

Jim retired after a career in management. He and Connie have four children, 10 grandchildren and four great-grandchildren.

Although he tries to keep a positive attitude, Jim said it would be difficult to say he hasn't been discouraged at times.

"It is tough. There is no question it is tough," he said. "If you've got something you've got something. That's all there is to it. So, let's beat it. I am Type A, very competitive and, by God, we're going to beat it."

Prognostic and Predictive Markers in Breast Cancer

The pathologist has, in modern times, acquired a more important role in the management of breast cancer. His involvement goes beyond the correct morphologic diagnosis, including grading and staging of cancer. Clinical breast oncologists make treatment decisions based on phenotypic and genotypic characteristics of the tumor, such as the presence of hormone receptors and the HER-2/neu oncogene status.

ER/PR

Estrogen and Progesterone receptor status of a primary breast tumor is not considered a major prognostic indicator, however, it is a powerful predictive marker of response to hormonal therapies and tamoxifen. ER/PR determination by immunohistochemistry remains the most reliable method to determine hormone receptor status in breast cancer. Monoclonal antibodies offer the highest level of sensitivity in detecting hormone receptors in breast cancer.

HER-2/neu

Amplification of the HER-2/neu gene and related protein overexpression are found in 10-20% of breast cancers. This gene alteration can be studied either by immunohistochemistry (IHC) looking for protein overexpression, or by fluorescence in situ hybridization (FISH) looking for gene amplification. In normal breast epithelium and in breast cancers without HER-2/neu alterations, techniques such as FISH detect two HER-2/neu signals – one on each copy of chromosome 17, and IHC shows low or absent signal representing HER-2/neu protein expression. When employing FISH technique in this setting, simultaneously looking at the HER-2/neu gene and the chromosome 17 centromeric region, the ratio of HER-2/neu to chromosome 17 signals is less than 2. In breast cancers showing HER-2/neu alterations, gene alteration is invariably present, as defined by a ratio of HER-2/neu to chromosome 17 signal of greater than 2, and IHC shows a strong membranous pattern of expression. HER-2/neu overexpression/gene amplification is an independent prognostic marker of clinical outcome in breast cancer, given the increasing role of trastuzumab (Herceptin®) in breast cancer treatment. It assists in determining which breast cancer patients would benefit from treatment with this immunotherapy directed at the HER-2/neu protein. The presence of these alteration in breast cancer can also aid in predicting positive response to doxorubicin (Adriamycin) based adjuvant chemotherapy, as well as resistance to tamoxifen, even in the setting of ER/PR expression.



Carlos N. Machicao, MD
Medical Director, Pathology



Jody Long, RHIT
Oncology Research Analyst



Misty Frank
Oncology Research Analyst
Assistant

Cancer Registry

What is a Cancer Registry?

Cancer registries collect information about cancer patients. Hospitals, physicians' offices, and pathology laboratories send information about cancer cases to the cancer registry. Cancer registrars then transfer the information from the patient's medical record to a computer database. The information from cancer registries can be used to:

- Monitor cancer trends over time.
- Direct the planning and evaluation of cancer programs.
- Educate physicians and other healthcare professionals.
- Improve patient care.

The UVMC Cancer Registry maintains all records in accordance with applicable federal and state laws. The State of Ohio requires timely reporting to the Ohio Cancer Incidence Surveillance System (OCISS) in order to monitor cancer incidence across the state.

In addition, as part of our accreditation as a Community Hospital Cancer Program by the American College of Surgeons Commission on Cancer (ACoS – CoC), we submit data annually to the National Cancer Data Base (NCDB).

What type of data is collected?

The data collected by a cancer registry includes:

- Patient demographics, medical history, and co-existing conditions.
- Information about the tumor such as the size, site, and stage at time of diagnosis are also collected to accurately describe each patient's cancer.
- Treatment provided to the patient, such as surgery, radiation therapy, chemotherapy, and hormone therapy are also recorded.
- Follow-up information is collected on each patient to chronicle the outcomes of their cancer treatment.

Cancer Conferences

The UVMC Cancer Registry also coordinates two Cancer Conferences each month. On the second Monday of the month is the Facility-wide Cancer Conference. These conferences offer educational opportunities as well as multidisciplinary patient-oriented discussions with representatives from Radiation Oncology, Medical Oncology, Surgery, Diagnostic Radiology and Nuclear Medicine, Pathology, Nursing, Hospice, Cancer Patient Services, Palliative Care, and Pastoral Care. On the fourth Monday of each month is the Physicians Cancer Conference, where the physicians and those involved directly with the patients can discuss each case in more detail.

To schedule a case for discussion at a Cancer Conference, please contact the Cancer Registry at 937-440-4829 or 937-440-4830.

Upper Valley Medical Center Cancer Registry 2009 Statistical Review*

Jodi Long, RHIT
Oncology Research Analyst, Cancer Registrar

Registry Staff

The Cancer Registry is staffed by two cancer registrars for 1.5 FTEs.

Continuing Education of Cancer Registry Staff was provided by:

- The Miami Valley Cancer Registrars Association (MVCRA)
- The Ohio Cancer Incidence Surveillance System (OCISS) staff
- The American College of Surgeons Commission on Cancer (ACoS-CoC)
- Elekta Impac Software staff and online programs
- The National Cancer Data Base (NCDB)
- The American Health Information Management Association (AHIMA)
- The Miami Valley Health Information Management Association (MVHIMA)
- The North American Association of Central Cancer Registries (NAACCR)

Total Caseload since 1985: 8,878

Analytic case follow-up rate: 82%

Reported aggregate data to:

- *The Ohio Cancer Incidence Surveillance System (OCISS)*

All cases abstracted and required by OCISS for the year 2009.

- *The National Cancer Data Base (NCDB)*

In 2009, UVMC's Cancer Registry responded to the 20th Annual Call for Data.

Data was submitted for the accession years 2008, 2003, 1998, and 1988.

*Additional statistics, such as comparison by site, gender, class of case, etc. will be available online at <http://www.uvmc.com/uvmchome.aspx>, under Cancer Care Center, Cancer Care Reports.

Jim Palsgrove

Jim Palsgrove says he's living proof of the value of routine blood tests.

The 78-year-old Troy native began 2010 with a welcome change in his daily routine. No longer dotting his calendar were the daily trips to the UVMC Cancer Care Center for radiation treatments. He'd driven to the center a few miles each weekday over eight weeks for the treatments following discovery of prostate cancer last summer. His cancer was diagnosed after one of his twice yearly blood tests showed an elevated prostate-specific antigen (PSA).

Palsgrove's 43rd and final radiation treatment came on Dec. 31, 2009. "I didn't have to go into a new year," he said with a smile. On his final day of treatment, Palsgrove was presented with a "diploma" from the Cancer Care Center staff.

"I had teased the girls (working in Cancer Care). I asked 'Do I get a certificate or diploma or anything for doing this?' They came out with a diploma and gave it to me. I got emotional," Palsgrove recalled.

ADVICE from Jim Palsgrove

- Keep active.
 - Take care of your body and your health.
 - Have blood work done regularly.
 - Listen to the doctors and what treatments they say are necessary.
 - Go into treatment with a positive attitude.
 - Have faith.
-

Jean Heath, Director of the Cancer Care Center, assured Palsgrove that tears are not uncommon as treatment concludes.

"We have a lot of patients who feel that way. You have cancer. You went through treatment. You are putting it behind you," she said.

Palsgrove mentioned by name each Cancer Care Center employee who worked with him. "They are great people.

They treated me wonderful," he said. "I never had to wait. I was usually in and out of here in 20 minutes. I never felt a thing."

Palsgrove, a Korean War veteran, retired from the CSX railroad after 43 years of service. He and his wife of 56 years, Shirley, have two children, three grandchildren and seven great-grandchildren.

When he was told he had cancer, Palsgrove was scared. He discussed that reaction with Ronald Setzkorn, M.D., radiation oncologist and Director of the UVMC Cancer Care Center.

"I said 'You know what, cancer is a very scary word and it really scares me.'"

Dr. Setzkorn asked Palsgrove a series of questions, addressed his concerns and helped him settle on a treatment plan after Palsgrove read literature and checked out options by doing Internet research.

As he underwent treatment, he fielded a variety of questions from friends, such as whether the treatment hurt. He used the questions as an opportunity to educate about cancer detection and treatment.

"You need to get your blood work twice a year... for a PSA. Do not think that you might be the one who will not get it. Take care of your health because, if you don't, something could happen and it could be too late for proper treatment," he said.

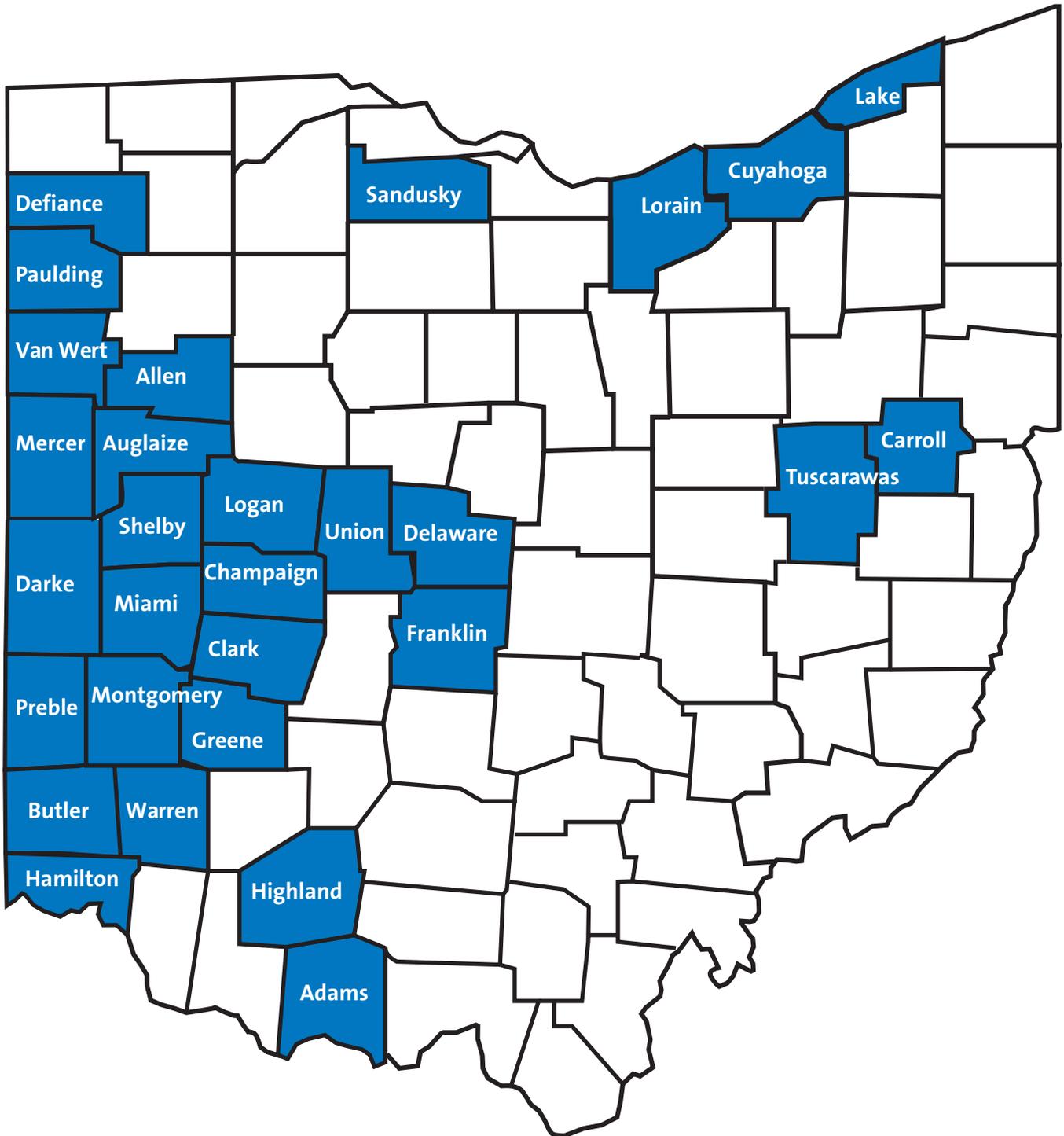
Palsgrove said remaining active – he rides a bike, walks and works a couple of days a week at Baird Funeral Home - and monitoring his health have paid off.

"I hear people say, 'I never go to the doctor.' I do. I don't want something wrong, but I want to find out if there is something wrong so I can take care of my problem."

He also takes care of those who take care of him, treating the Cancer Care Center staff to Esther Price candy when his treatment had ended.

His accompanying handwritten note remains on the door of the center break room's refrigerator. It reads: "I really do appreciate how well you took care of me. You are a good team. Thanks, and enjoy."

UVMC has served as the location of choice for treatment of cancer for patients from these 29 counties in Ohio, as well as from over 30 other states.

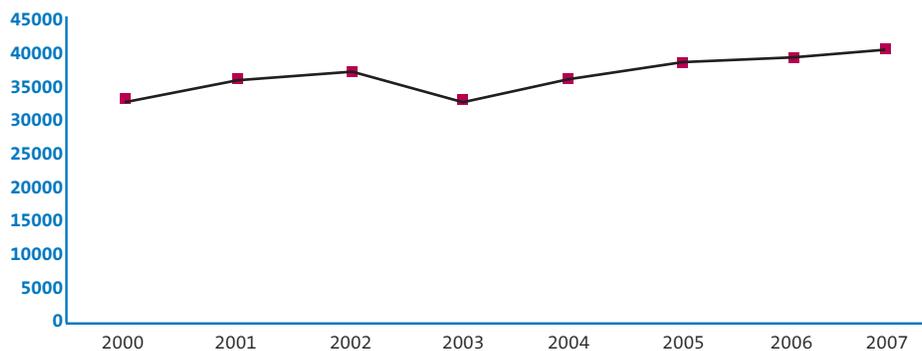


Outcomes Analysis: Focused Site Study: Melanoma

By Dr. L. Stewart Lowry, MD, FACS

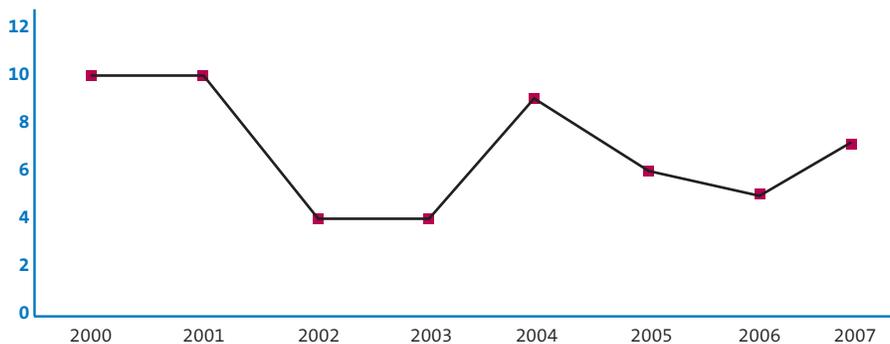
In the United States, the incidence of melanoma is increasing dramatically. In men, it is the most rapidly increasing malignancy and, in women, second only to lung cancer. The incidence by year in the National Cancer Data Bank (NCDB) can be found in Figure 1. A clear increasing trend can be seen.

Figure 1:
Incidence by year NCDB



We have not seen this at Upper Valley Medical Center (UVMC). There is no increase in trend. See Figure 2.

Figure 2:
Incidence by year UVMC



This is likely related to the small number of patients. There were only 55 patients in this 8-year interval.

As with nearly all malignancies, the outcome of melanoma initially depends on the stage at presentation. It is estimated that nearly 82-85% of patients present with localized disease. Localized disease is usually defined as Stages 0-II. The stage at diagnosis for UVMC versus NCDB for the years 2000-2007 can be found in Figure 3.

At UVMC, 67% of patients were Stages 0-II versus 58% at NCDB. UVMC has a higher percentage in this early stage group. This might be because we have fewer that are of unknown stage or NA stage compared to the NCDB.

Survival of melanoma for the years 1998 to 2002 inclusive can be seen for NCDB and UVMC in Figures 4 and 5 respectively.

The survival is superior at UVMC for all stages except for Stage I (87% at UVMC vs. 91% at NCDB). Of note, the patients with regional disease (Stage III) had an 80% five-year-survival rate at UVMC compared to 53% for NCDB. There were only 5 patients in this stage group at UVMC.

CONCLUSION

Melanoma patients are relatively rare in our area. We have yet to see a discrete increase in incidence. They are probably diagnosed early and even our patients with regional disease do well compared with the rest of the NCDB. There are no problem areas when focusing on this site.

ACKNOWLEDGMENT

The data for this study was obtained from the NCDB Statistics section at CoC Datalinks and our Cancer Registry at UVMC.

i Jemal A, Siegel R, Ward E, Hao Y, Xu J, Thun MJ. Cancer statistics, 2009. CA Cancer J Clin. 2009;59:225-249.

ii Balch CM, Gershenwald JE, Soong SJ, et al. Final Version of 2009 AJCC melanoma staging and classification. J Clin Oncol. 2009; 27:6199-6206.

Figure 3:
Stage at Diagnosis UVMC vs. NCDB

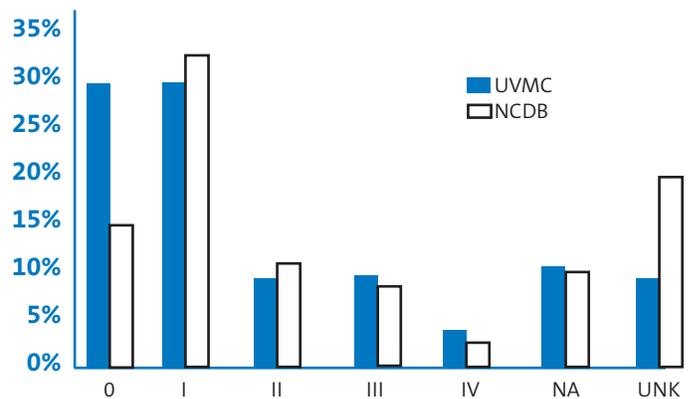


Figure 4:
NCDB Survival by Stage

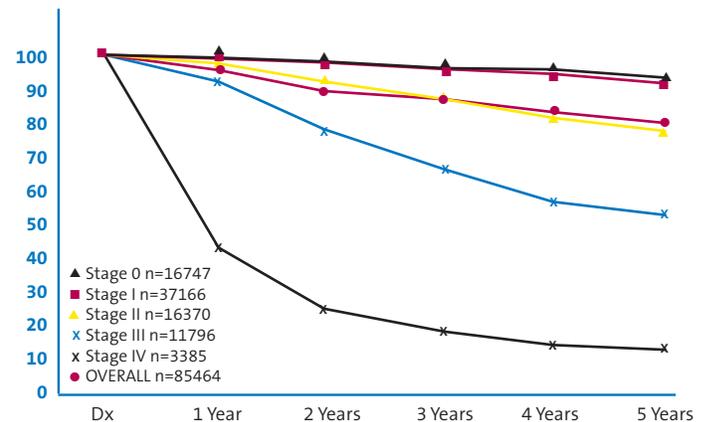
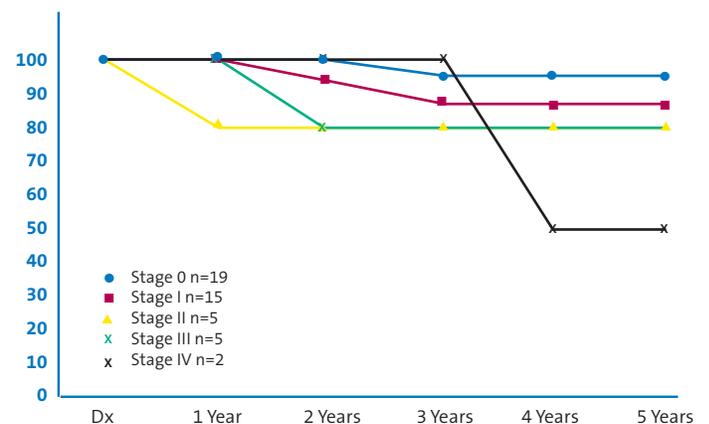


Figure 5:
UVMC Survival by Stage



Performance Rate Improvement for 12RLN 2004-2008

By Dr. L. Stewart Lowry, MD, FACS

INTRODUCTION

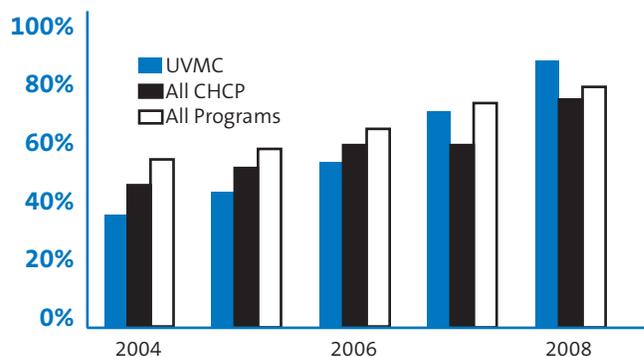
12RLN is a quality initiative of the Commission on Cancer. It is one of six initiatives under the Cancer Program Practice Profile Reports (CP3R). It stands for "At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer."

This initiative was started because the survival of colon cancer patients decreases as the absolute number of positive lymph nodes increases.¹ Identifying all positive nodes is essential to accurate staging and planning of adjuvant chemotherapy. It has been presumed that harvesting 12 or more regional lymph nodes is a surrogate marker for more accurate staging. This is an area of controversy.

The aim of this study is simply to review the performance rate of this initiative at our institution and how it has changed over time and to compare our performance to available groups within the CP3R database. This information will be shared with the Cancer Committee at UVMC and included in the annual report for dissemination to the medical staff and other interested parties.

METHODS

A query of CP3R database compiled within parameters of like entities.



RESULTS

The overall performance rates are depicted in the above Figure by year.

DISCUSSION

The 12RLN data is now an established quality initiative. Whether it truly is a surrogate marker for more accurate staging is controversial. The performance rates of UVMC and all programs have improved in the study interval. In 2008, UVMC had 90.0% of eligible patients with 12 or more lymph nodes in their resected specimen. This is a marked improvement compared to just four years prior. Some of the initiatives started by our program included increasing awareness of the 12RLN initiative both among the surgeons and the pathologists. Our pathologists will now search twice and use fat reducing technique to comply with the initiative. Our performance now exceeds that of all community hospital cancer programs (CHCP) and even the overall performance of all programs including tertiary referral centers.

ⁱ Chang GJ, Rodrigas-Bigas MA, Skibber JM, Moyer VA. Lymph node evaluation and survival after curative resection of colon cancer: systematic review. J Natl Cancer Inst 2007;99:433-441.

Lynch Syndrome (HNPCC Hereditary Nonpolyposis Colorectal Cancer)

Sarah Jones, MS, RN, ACNS-BC, AOCNS
Oncology Clinical Nurse Specialist

Lynch syndrome, also known as Hereditary Nonpolyposis Colon Cancer (HNPCC), is the most common of the hereditary colon cancer syndromes and is believed to account for 3% to 5% of all colorectal cancers. It is now

known that Lynch syndrome results from an inherited mutation in one of the mismatch repair (MMR) genes. Normally, MMR genes produce proteins that identify and correct base-pairing mismatches that can occur during DNA replication. Consequently, a mutation that inactivates an MMR gene leads to accumulation of other mutations which significantly increases the likelihood of developing cancer. Four MMR genes (MLH1, MSH2, MSH6 and PMS2) have been linked to Lynch syndrome. Germline mutations in MLH1 and MSH2 account for the vast majority of detected mutations in families with Lynch syndrome.<http://www.myriadpro.com/references>

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Lynch Syndrome Cancer Risks

Individuals with Lynch syndrome have a 25% increased risk of colorectal cancer by the age of 50, and up to 82% by age 70. The risk for certain other cancers, primarily endometrial (up to 71%), ovarian (up to 12%) and gastric (up to 13%) is also increased in Lynch syndrome. Mutation carriers previously diagnosed with cancer also have a significantly increased risk of developing a second primary cancer of up to 50% within 15 years of the first diagnosis.

Identifying Patients at Risk for Lynch Syndrome

Finding patients at risk for Lynch syndrome and following up with them is perhaps the most critical step in potentially changing hereditary cancer outcomes.

The following “red flags” in a patient’s personal or family history may indicate an increased risk for Lynch syndrome and help identify candidates for testing.

- Colon cancer before age 50
- Endometrial cancer before age 50
- 2 or more Lynch-associated cancers**
- A previously identified Lynch syndrome mutation in the family

**Lynch-associated cancers include colon, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas.

Medical Management Strategies That May Reduce the Risk of Cancer

Colon Cancer

Increased Surveillance for Colorectal Cancer

- Colonoscopy every 1-2 years beginning between age 20 and 25, OR 10 years before the earliest age of a patient’s family member diagnosed with colorectal cancer - whichever comes first
- Consider annual colonoscopy after age 40
- For MSH6 mutation carriers consider initiating colonoscopy screening at age 30-35 or 10 years before the earliest age of a patient’s family member diagnosed with colorectal cancer. This is due to the later average age of onset in MSH6 mutation carriers

Surgical Management of Colorectal Cancer

- If colon cancer is diagnosed (or more than one advanced adenoma is found) in a patient with Lynch syndrome, total colectomy with ileo-rectal anastomosis OR hemicolectomy is an option

- In patients unwilling or unable to undergo periodic colonoscopy screening, prophylactic total colectomy with ileorectal anastomosis may be an option based on carrier status alone

Endometrial and Ovarian Cancer

Surveillance for Endometrial and Ovarian Cancer

- Consideration of referral to a gynecologic oncologist to discuss screening options that can include gynecologic exam, transvaginal ultrasound, endometrial aspiration and CA-125 every year, beginning between age 25 and 35

Surgical Management of Endometrial and Ovarian Cancer

- Prophylactic total abdominal hysterectomy and bilateral salpingo-oophorectomy is a risk reducing option for women who have completed childbearing
- May also be considered at time of colon surgery if postmenopausal or childbearing is complete

Surveillance for Other Lynch Syndrome-Related Cancers

- For gastric and duodenal cancer: Consider upper GI endoscopy (wide side viewing scope) at age 25-30 years and repeat every 1 to 3 years depending on findings
- For urothelial cancer: Consider urinalysis on an annual basis
- For CNS cancer: Physical examination on an annual basis

References

- Aarnio M, Sankila R, Pukkala E, et al. (1999). Cancer risk in mutation carriers of DNA-mismatch-repair genes. *International Journal of Cancer*. 81, pp. 214-218.
- Burke W, Petersen G, Lynch P, et al. (1997) Recommendations for follow-up care of individuals with an inherited predisposition to cancer. Hereditary nonpolyposis colon cancer. Cancer Genetics Studies Consortium. *JAMA*. :277, pp. 915-919.
- Giardiello FM, Brensinger JD, Petersen GM. (2001) AGA technical review on hereditary colorectal cancer and genetic testing. *Gastroenterology*, 121, pp. 198-213.

Clinical Trials at Upper Valley Medical Center

Robin Holcomb, RN, BSN, OCN
Clinical Trial Coordinator

Participation in National Cancer Institute sponsored clinical trials is an option available to cancer patients at Upper Valley Medical Center (UVMC) through the Dayton Clinical Oncology Program (DCOP). All of the clinical trials are reviewed by an Institutional Review Board from Wright State University. Clinical Trials are designed to answer questions regarding new ways to prevent, detect, diagnose, and treat cancer. The mission of DCOP is “to reduce cancer incidence and mortality through improved treatment and prevention by offering national state-of-the-art cancer research to the local communities.”

There are several phases of clinical trials, Phase I, Phase II, and Phase III. Phase I trials are the introduction of a new drug and have a relatively small number of participants. These are typically patients that have exhausted all other treatment options and no other options are available. Phase II trials study the effectiveness of the drugs on the cancer and measure any side effects of the treatments being tested. Phase III trials compare the results of the new treatment regimen with the current standard of care. These test if the new treatment regimen has better survival rates, fewer side effects, and possibly require fewer treatments than the current standard. Currently at UVMC we have Phase II and Phase III clinical trials available to our patients.

The general public is usually unaware or misinformed of cancer clinical trials. Most adults in the US agree that clinical research is important and participants are

making a significant contribution to science. Although they agree with this statement, some still view clinical trials as being a “guinea pig” for medical research. The truth is patients are always provided with at least the standard of care or a new treatment (thought to be better than the standard treatment). Patients on cancer clinical trials are monitored closely and kept informed of any changes. The trials are scrutinized for patient safety and ensure the patient is constantly informed and knowledgeable regarding treatment decisions. Among US adults surveyed who have participated in cancer clinical trials, 84% stated they would do so again if given the chance. Currently at UVMC we have 47 patients who are actively being followed on cancer clinical trials. Some patients are on a couple of trials, not only for their cancers but their quality of life and side effect management. For more information on the types of clinical trials available at UVMC or to refer a patient for involvement in a study, please contact Robin Holcomb, RN, BSN, OCN at (937) 440-4822.



Robin Holcomb, RN
Clinical Trials Coordinator



“Every evening I turn my worries
over to God.

He’s going to be up all night anyway.”

- Mary C. Crowley

Breast Cancer Rehabilitation

Carl Atkinson, OTR/L, MLD/CDT

What Type of individual would be appropriate?

Post surgical breast cancer patients that have: limited (UE) and trunk (AROM), patients with pain that is consistent along the chest wall/flank and arm, tight and immobile scarring, tightness anywhere along the chest wall, expected areas of swelling typically seen post surgically, swelling along the trunk, axilla or scapula and nowhere else, inability to perform normal daily functions, excessive fatigue, and post –radiation fibrosis.

Manual Treatment of Soft tissue dysfunction:

- Myofascial release is a gentle form of manual therapy that has been proven effective in the treatment of acute and chronic fascially based pain and dysfunction
- Use soft tissue taping techniques and methods that are appropriate for upper quadrant dysfunction of oncologic patients with soft tissue hypo mobility.
- Evaluate and provide soft tissue mobilization: soft tissue massage/myofascial release with movement to facilitate improved range of motion and lymphatic drainage of the upper quadrant.
- Utilize preexisting understanding of the stages of wound and tissue healing to treat post-surgical patients.
- Special attention would be given to the evaluation and treatment of axillary web syndrome/cording

Comprehensive Scar Management

- Elastic sports taping using kinesiotape to modify and shape scar tissue that if left unchecked would hamper lymphatic flow.
- Application of scar modifiers using: foam packs, vibration, self -myofascial release, scar molds, prefabricated product lines.
- Evaluation and suggestions for clothing and prosthetic choices that may impact scar tissue formation and lymphatic flow.
- Manual scar release techniques.

Re-establishing and Maintaining Functional Movement and Strength

- The shoulder for all its wonderful motion is one of the most unstable joints in the whole body. The shoulder is highly dependent on a complex balance of musculature to allow for movement.
- Soft tissue hypomobility can lead to poor active range of motion, increased pain, protected patterns of movement, decreased functional strength, and general fatigue.
- Clinical evidence indicates that breast cancer survivors are at higher risk for scapular-humeral dysfunction
- Restoration of pre condition functional activity levels (through individualized exercise programs)

Reduce and Define causes of pain post-surgically:

- Is it myofascial?
- Is it postural?
- Is it both?

Comprehensive Education in Infection and Lymphedema Risk Reduction

- Adaptation of work and daily ADL routine

Time spent in evaluation with patient would effectively screen for post surgical lymphedema as opposed to post-surgical edema (not heavily protein based).

Typically these patients show dramatic improvement in AROM after several visits and most studies show that treatments are completed in 6-12 treatments. This has been my experience with this type of patient as well (provided no lymphedema involvement).

I would like to extend the opportunity to benefit from these treatment techniques to patients that do not have lymphedema and may be having difficulty with pain or tight scar tissue as a result of needed surgical intervention.

The primary diagnosis of breast cancer with an ICD-9 code of 174.9 has covered all the patients that we have worked with in a Breast Cancer Rehabilitation setting.

Please contact me any time to discuss a particular patient that you may feel would benefit from what our therapeutic staff can offer.

Palliative Care Program

The landscape of health care presents many challenges both technical and financial. Recently the focus of legislators has turned to reform of the health care system. However, reform will need to address the growing number of health care needs of an aging population. As baby boomers retire, the demand on the healthcare system will continue to grow.

Currently 25% of Medicare enrollees comprise 85% of total Medicare costs. In fact 50% of all Medicare dollars are spent at the end of life. Palliative Care has proven to reduce health care cost by assisting patient/families to make realistic health care choices. Patients with complex health problems may be poorly served by high-cost, high-technology tests and treatments. These tests may result in unnecessary stress and suffering without significantly influencing the course of the patient's illness.

Palliative Care is care and treatment that enhances comfort and improves quality of life. Utilizing a comprehensive approach, Palliative Care helps to provide care for patients who have been diagnosed with serious or life-threatening illness and can begin at the time a patient is diagnosed. Different from Hospice care, Palliative care may continue along with curative or life-prolonging measures. The primary goal of Palliative Care is to prevent or relieve the many and various burdens imposed by diseases and their treatments and consequent suffering.

Palliative Care addresses symptoms in all facets of patient care including physical, emotional, psychosocial, and spiritual issues. As the disease process advances, the number and intensity of symptoms tend to increase. The Palliative Care team member will work to support the patient's comfort in a way that is consistent with the patient's values and expressed wishes. The ultimate goal for Palliative Care is to provide the best quality of life possible given the disease process.

In the current landscape of health care, Palliative Care plays an important role. Palliative Care improves quality of life through symptom management, communication, and supportive care. In addition, Palliative Care saves health care dollars. As the need for health care services increase, Palliative Care is a wise choice for improved quality of life and reduced suffering.

To refer patients or to find out more about the services provided, please contact the Palliative Care Clinician, Lora Wilcher, RN, MSN at (937) 440-4828.



Lora Wilcher, RN, MSN
Palliative Care Clinician

Gretchen Roeth

After more than 30 years experience teaching others, it was Gretchen Roeth's turn to learn during her battle with cancer.

A retired fourth grade teacher in the Piqua schools, Roeth was diagnosed last summer with endometrial cancer after checking with doctors when "something didn't seem right" to her.

She underwent 31 radiation treatments, ending in mid-January, at UVMC Cancer Care Center.

"I was nervous. I was afraid. My blood pressure went through the ceiling," Roeth said. "All of the (Cancer Care) therapists walked me through things ... They knew I was a mess, but they were very good with it. Everybody was very patient with me."

Jean Heath, Director of the Cancer Care Center, said the center prides itself on individualized care for patients.

"We know every time somebody walks through that front door they have the fear of what is behind the door. They ask, 'What is going to happen to me?'" Heath said. "This staff knows everybody is different. It is not a cookie cutter process."

Roeth said she was encouraged to undergo treatment at UVMC by her sister in law, who received breast cancer treatment at the center a few years ago.

"I talked to her quite a bit. She was very helpful," Roeth said. "She said, 'You don't want to go someplace else. They can take care of you.' And, they did. I felt like I was The Patient. I never felt like I was a number."

After reading pamphlets provided by caregivers, talking with doctors and doing some Internet research, Roeth said she felt more comfortable, but never hesitated to ask questions. To prepare for appointments, she'd write down questions, instead of asking off the cuff.

"No question was too stupid. I never felt like I asked a question that they didn't want to answer," she said.

Heath said the center advises those looking on the Internet to visit reputable sites such as ones by the American Cancer Society and the National Cancer Institute. "There is so much out there that it can overwhelm you, and some of it is not right," Heath said.

Among lessons Roeth learned along her cancer treatment journey was to document. She compiled a family medical history including information on events such as any cancer and age when they occurred for her and husband, Gary, plus their parents.

"I have shared it with my kids so we all know what happened to everybody, and when ... It has been very helpful," said Roeth, who works part time at the Piqua YWCA. She and Gary have two children and a granddaughter.

An awareness of one's body also is important, she said. "A doctor told me to know your body, listen to your body. If something isn't right or it bothers you, then go see somebody about it," she said.

"To me it was like other people have cancer, but that wasn't going to happen to me. Then, when it does, it was like, 'Oh, gosh, I really need to be a lot more aware.' I have learned."

Although she was scared, Roeth said she took a positive approach to her treatment.

"You learn that life is precious and you take care of things. It is a whole attitude," she said. "People can make it horrible, and it doesn't have to be horrible. There are better days ahead."

ADVICE from Gretchen Roeth

- Be comfortable with your doctor, know your doctor.
 - Know what's ahead as far as you can.
 - Bring questions to doctor and treatment appointments.
 - Take care of yourself. If you have any symptoms or signs, have them checked out.
 - Be persistent.
 - Compile a family history for your use, and your children's.
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Robin Supinger, ACS, PN
Patient Navigator for the
American Cancer Society

American Cancer Society Patient Navigator

The UVMC Cancer Care Center has been home to the American Cancer Society Patient Navigator program's Robin Supinger since 2001. During this time, Robin has provided resources, information and support to cancer patients, their families and their caregivers as well as collaborated on many community outreach programs.

Robin has helped patients obtain free or reduced rate transportation to treatments, doctor appointments, and support group meetings. She has also located financial assistance for medicine co-pays, gasoline, food, utilities, rent/mortgage assistance, supplies and equipment.

In 2009 she completed 216 requests for patients from three counties in the UVMC area. One particular population of patients that Robin has worked with extensively in the last year is patients who are uninsured or underinsured. She assisted patients to get assistance from county, state, and federal programs, such as Medicaid and Social Security Disability so that they could get treatment without long delays.

Please call (888) 227-6446, ext. 8070 to speak to Robin for more information or to schedule a presentation for your office or community group.

Hospice of Miami County

Hospice of Miami County supports the outstanding care provided by the UVMC Cancer Care Center, and frequently augments its efforts in bringing compassionate care to people facing life-limiting illness in Miami County. In

2009, Hospice of Miami County served 443 patients and families.

The staff of nurses, social workers, chaplains, aides, and volunteers provided over 28,000 patient visits totaling over 39,500 visit hours.

The Hospice Generations of Life Community Bereavement Center opened in 2008 and has gained recognition throughout the community as a premiere resource center for the residents of Miami County. Bereavement Support Groups now include preschool, elementary, and teenage children as well as adults. The center is free and open to the public. Those wishing to utilize the services do not have to have a Hospice connection.

Hospice of Miami County is committed to meeting the end-of-life care needs for residents of Miami County. We look forward to continued collaboration with the UVMC Cancer Care Center in achieving this goal.

For more information please visit online at www.homc.org



Ostomy Support Services

Ostomy is a surgical procedure in which an artificial opening is made to permit the drainage of waste products into an appropriate organ or to the outside of the body. The purpose of the group is to provide support and education for the person with an ostomy and their family.

There is an educational program presented at the meetings. There is also time for questions to be asked and answered either individually or within the group. By talking with other persons who have an ostomy, one can learn many things from the “experts” which can make life with an ostomy easier.

The Miami/Shelby Ostomy Support Group continues to meet monthly in the Cancer Care Center lobby at 7 p.m. the first Wednesday of each month with the exception of January and July. We actively seek new members. Meetings are open to any interested person. Those with an ostomy, their family, health care professionals, and students are welcome.

Breast Cancer Support Group

UVMC has an active Breast Cancer Support Group, sponsored by the Cancer Care Center. The mission of the group is “empowering women to cope with the day-to-day realities of cancer before, during, and after treatment.” Starting in October 2010, the support meeting will be held on the second Tuesday of the month at the Farmhouse on the UVMC Main Campus.

The meeting is open to anyone affected by breast cancer, including cancer survivors, families, and friends, and various topics are covered. There is no cost to attend and it does not matter if you had your surgery or treatments at UVMC or another institute.

Please contact Chris Watercutter at (937) 440-4638 or (937) 492-1033 or Robin Supinger at (937) 440-4820 for more information.



“The secret of health

for both mind and body is not to mourn
for the past, worry about the future, or
anticipate troubles, but to live in the
present moment wisely and earnestly.”

- Buddha

Sally Rudy

Always an educator, Sally Rudy began researching invasive ductal carcinoma the day a diagnostic mammogram found her breast cancer.

“Right away, I went home and did research. I just feel it is very important to be educated about your health, so I learned as much as I could about it. I’ve always been that way,” said Rudy.

After 30 years of teaching at Covington Elementary School, she retired in 2007.

The cancer was found in January 2009 following screening and diagnostic mammograms.

“I thought that maybe that was meant to be, so I didn’t have to miss school to deal with the cancer,” Rudy said of her diagnosis following retirement.

After undergoing a biopsy and then surgery in March 2009, she made daily trips to the UVMC Cancer Care Center for 37 radiation treatments.

As Rudy recently discussed her journey through diagnosis, surgery and treatment, she flipped through a pink camouflage journal, a gift to her from her son, Brian, following her diagnosis.

Not one to write faithfully in a journal, the pink book became Rudy’s “catch all” for important information. Among its contents are physicians and appointments, names of who brought her food during treatment, a prayer list and details of what happened and when.

ADVICE from Sally Rudy

- Stay positive, knowing that it is treatable.
 - Take one day at a time with your decision-making.
 - Surround yourself with people who can be supportive in a positive way.
 - Educate yourself.
 - Take notes when you go see the doctor.
 - Bring questions when you go to your doctor’s appointment. Ask questions if you don’t understand something.
 - Realize you are not alone in this journey.
 - Take care of yourself: get plenty of rest, eat well.
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For mother and son, the cancer journey was not a new road. They’d traveled together 11 years before as Brian dealt with testicular cancer while a college student.

With Brian’s diagnosis, Rudy also had hit the computer for research.

“With Internet research I know you have to be careful,” she said. “I just tried to put two and two together to figure out maybe what was wrong ... But, I never second-guessed any of the professionals.”

During her care, Rudy said she asked many questions in deciding to undergo radiation treatment. She praised Dr. Ronald Setzkorn, radiation oncologist and Director of the Cancer Care Center, for his guidance. “He really laid my fears to rest, (assured me) that I was doing the right thing,” she said.

Her son’s experience helped Rudy deal with her own cancer. “You meet each step head on, one step at a time. That is what I’ve learned to do with things like this, and it has worked out well,” she said.

Having supportive family, friends and caregivers also is important. Her husband of 36 years, Bob, was always nearby and daughter, Jill, a nurse in California, was there after surgery to help her mother, including organizing paper work in an accordion file for easy access and updating.

“It is a family disease,” Rudy said of cancer. “I know that first-hand because when I wasn’t the patient, and my son was, it affected the whole family. When you are the patient, you tend to focus on yourself.”

To help keep family and friends informed of what was going on Rudy, shortly after diagnosis, created on e-mail a “cancer list” of people she was going to tell.

“I kept them updated because I knew, first of all, it eliminated my husband from the painful process of having to tell all of our friends and family,” she said. “It also created this huge support from people who lived far away because I got e-mails back saying ‘We are praying for you.’ It was pretty neat ... It helped us all out.”

For Rudy, the cancer journey helped create more appreciation of life. “You certainly don’t sweat the small stuff anymore. It is important to embrace life and live each day to its fullest ... It has made me more serene and calm about anything, really.”

 “Once you choose hope
anything’s possible.”

-Christopher Reeve



Upper Valley Medical Center

Premier Health Partners

Cancer Care Center

3130 N. CR25A, Troy, Ohio 45373

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