

VA



**U.S. Department
of Veterans Affairs**
Stratton VA Medical Center

2018 CANCER PROGRAM Annual Report



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COMPREHENSIVE CANCER COMMITTEE

The Cancer Committee includes representatives of professional specialists as recommended by the American College of Surgeons Commission on Cancer with areas of responsibilities including: coordinating educational activities for nursing staff, students and professionals; coordinating multi-disciplinary treatment groups such as Oncology, Radiation Oncology and Hematology related clinics and Tumor Board; and overseeing the functioning of the Tumor Registry.

The Cancer Committee is responsible for discussing the diagnosis and treatment of patients with malignancy within the facility as well as reviewing the medical records of cancer patients.

2018 MEMBERSHIP

REQUIRED:

E. Ball, CCRP	Representative Clinical Research Coordinator
S. Bhatia, MD	Representative Radiation Oncology
K. France, RN	Representative Radiation/Oncology Nurse
T. Jardine	Cancer Program Administrator
R. LaTourette, MS, RD, CSO	Community Outreach Coordinator/Rep Nutrition
A. Lupinetti, MD	Representative General Surgery/QM Coord.
B. McCandless, MD	Representative Diagnostic Imaging-Nuclear Med
L. McCarthy, MD	Representative Pathology/Laboratory
S. Mehdi, MD, FACP	Cancer Conference Coordinator/Chair/Medical Oncologist
P. Minkler, RN	Representative Hematology/Oncology Nurse
R. O'Malley, MD	ACoS Liaison/General Surgery
D. Pasquale, MD	Cancer Registry Quality Coordinator/Rep Hem
T. Thierbecker, LCSW, OSW-C	Representative Social Work
I. Uppal, MD	Representative Pain Control/Palliative Care
B. Williams, CTR	Tumor Registry CTR

ALTERNATES:

S. Casler, NP	Representative Pain Control/Palliative Care
T. Ferrario, MD	ACoS Liaison/General Surgery
R. Grembocki	Representative Clinical Research Coordinator
P. Hegener, MD	Representative Diagnostic Imaging-Nuclear Med
T. Kidder	Representative Social Work
E. Kim, MD	Representative Hematology/Oncology
Y. Lau, MD	Representative Radiation Oncology
M. Le, MD	Representative General Surgery
T. Norris	Representative Nutrition
R. Patel, MD	Representative Pathology/Laboratory
V. Thalody, MD	Representative Hematology/Oncology

AD HOC:

R. Dyer, OT	Representative Rehabilitation Medicine
M. Herrington, RN	Quality Improvement Liaison
D. Kupiak, R. Ph	Representative Pharmacy
A. Payne, MD	Representative Psychosocial
C. Reyes-Lopez/H. Park, MD	Representative Dental
J. Richter, SW	Representative American Cancer Society
M. Roth, MD/R. Grimm, MD	Representative Primary Care

***STRATTON VA COMPREHENSIVE CANCER COMMITTEE
MISSION STATEMENT***

The Comprehensive Cancer Committee supervises activities related to cancer treatment, control, education and reporting within the Medical Center. The committee maintains and expands activities within our community of Veterans to insure the broadest spectrum of quality care for patients.

The departmental reports data dates are January 1, 2018 thru December 31, 2018.

COMPREHENSIVE CANCER COMMITTEE CHAIRMAN'S REPORT

I am proud to report that our cancer program achieved re-accreditation by the Commission on Cancer (COC) in 2018. We have had accreditation for over 57 years. This major milestone every 3 years reconfirms our commitment to excellence in providing cancer care to our Veterans.

The Cancer Program in the Stratton VA Medical Center has over time evolved into a center of excellence with a dedicated, multi-specialty team which includes a Certified Tumor Registrar, chaplain services, medical oncology, radiation oncology, interventional radiology, surgical oncology, dental services, speech therapy, palliative care, dedicated oncology social worker, oncology nutrition & quality improvement.

Each year the members of the cancer committee set up goals/studies of quality improvement. We meet quarterly to ensure that we remain focused. Together, we make sure that the Veterans receive the highest level of care from prevention, diagnosis, treatment, and survivorship. The multi-specialty weekly tumor board provides unique opportunities to maintain evidence base standards.

The landscape of cancer care is undergoing enormous changes. These changes are challenging, requiring and increasing commitment of time, efforts & resources. The evolution of personalized medicine is exciting. We no longer look solely at chemotherapy for the treatment of cancer. Targeted therapies, immunotherapies, check-point inhibitors and growth-factor modulators are all in use as frontline treatment for advanced malignancies. Patients are now living longer. With longer life span the needs for constant improvement in nutrition and survivorship are becoming more demanding and challenging. The complicated pathway from early diagnosis to timely treatment and navigation is a very important tool. We were fortunate to hire two dedicated nurse navigators (also known as tumor trackers). The availability of dietitians in our oncology clinic has prevented many catastrophic weight losses and has improved the quality of life of the Veterans receiving cancer treatments. The involvement of our oncology social worker, in every patient with a new diagnosis of cancer has minimized the distress of extremely complicated treatments for cancer patients as well as care givers.

As you go through the achievements and accomplishments of various departments in this report, you will also find two very touching true stories; one from a physician who is fighting cancer herself, as well a very emotional reflection of the wife of Veteran who lost his battle with cancer.

The success of any cancer program depends upon an effective, multidisciplinary cancer committee. The backbone of the cancer committee is our CTR, Bernice Williams, a devoted & dedicated individual. She ensures that all goals & studies are accomplish in a timely manner.

In the end I am extremely thankful to our cancer committee members who sincerely, tirelessly and constantly contribute to improve the care of Veterans with cancer. I am indeed proud to be a part of this amazing care-giving team.

Syed Mehdi

Syed Mehdi, MD FACP
Chair Cancer Committee

2018 TUMOR REGISTRY REPORT

Bernice Williams, CTR

The Tumor Registry at the VA Medical Center has a reference date of January 1955 (27,814 alive/dead patients) and currently utilizes a computerized/manual system. In addition to registering and following patients with a diagnosis of malignancy, the Registry provides data for research and education to staff. Our data is captured and submitted in accordance with the guidelines and procedures are set forth by the American College of Surgeons Commission on Cancer, the State of New York, the Surveillance, Epidemiology and End Results (SEER) of the National Cancer Institute (NCI), National Cancer Database (NCDB) and the VA Central Cancer Registry (VACCR). Interfacing with all the components that make up the Cancer Program, the data collected by the Registry helps promote quality patient care for present as well as future cancer patients. The registry is currently staffed by Bernice Williams, CTR.

The Stratton VAMC Cancer program is accredited by the Commission on Cancer (CoC) as a Veteran's Administration Cancer Program (VACP). Our program's compliance with the CoC standards is committed to providing the best in cancer diagnosis and treatment.

Lifetime follow-up of patients included in the database supports clinical follow-up & surveillance of additional primaries. Follow-up data includes neoplasm status (free or residual/progressive disease), recurrences, subsequent treatment, and vital status. The Tumor Registry maintains a follow up rate for patients diagnosed from registry date 1955 as of 12/31/18 = 99%. *Non-analytical, basal and squamous cell cancers of the skin and in-situ of the cervix are excluded from the calculations of follow-up percentage.

The abstracting timeliness percentage cannot be calculated for 2018 due software issues. The American College of Surgeons has been made aware of this national VA issue, as abstracting timeliness has a requirement of 90%. The top five most frequently occurring primary site trends include Prostate, Lung, Bladder, Colorectal and Liver.

We strive to provide the highest quality database. We endeavor to achieve this through uniformity of data collection, annually physician chart review of 10% of our new cases, software edits checks, and accurate and timely follow-up information on our patients. Our ultimate goal is to contribute to the prevention and cure of cancer.

The Cancer Program continues to support the registry's educational activities which assist us to meet the Standard 1.10; Cancer Registrar Education which includes participating in cancer-related educational activities other than cancer conferences.

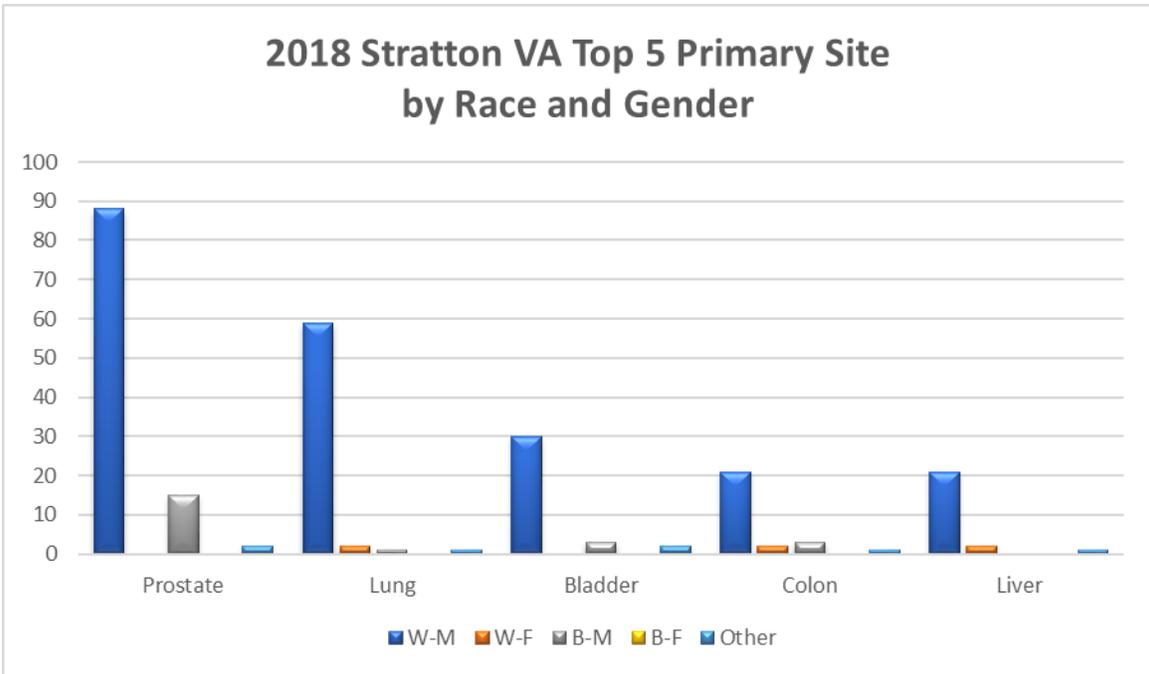
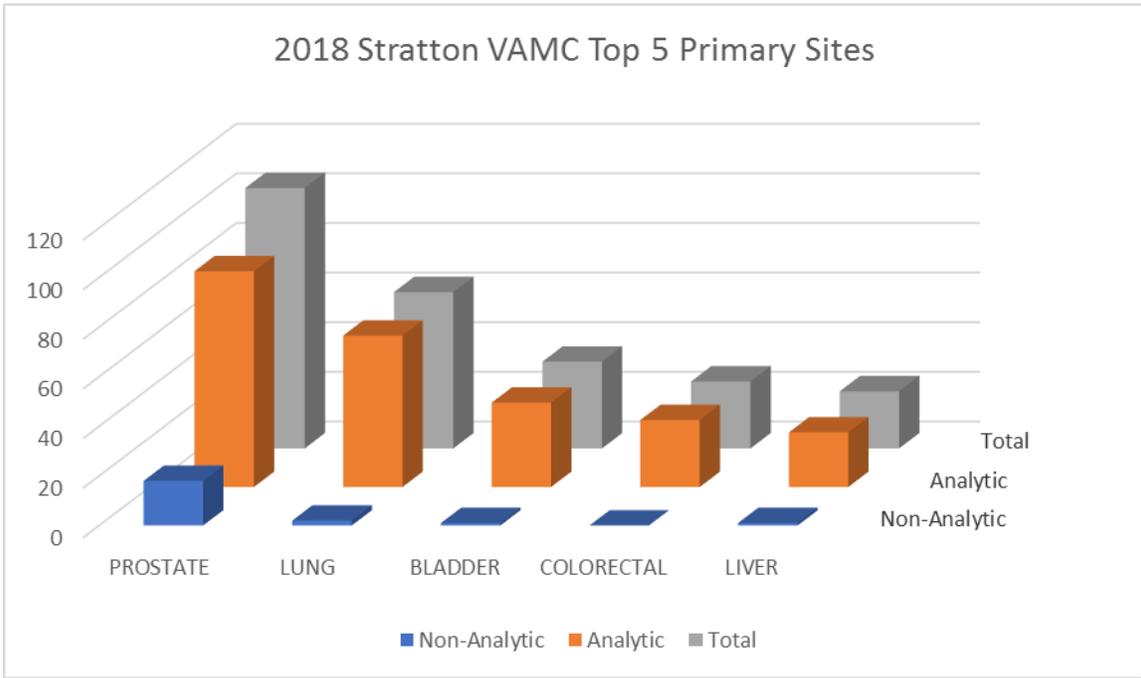
2018 TUMOR BOARD REPORT

Bernice Williams, CTR

Our weekly Tumor Board is a conference which includes both case presentation and a didactic program. Following each presentation, there is discussion of the case and review of the recommended staging and treatment modalities available. This ensures a multi-disciplinary and multi-specialty approach to the treatment of disease as well as providing education to the house staff, students, and allied health professionals in attendance. Continuing Medical Education credits are given to the physician staff for Tumor Board.

During 2018, there were 161 presentations (139/86% prospective and 22/14% retrospective) of new primaries, recurrences or follow-ups. Sites presented included: Bladder, brain, breast, colorectal, esophagus, kidney, liver, larynx, leukemia, lung, lymphoma, melanoma, nasal cavity, neuroendocrine, oral cavity, pancreas, prostate, tongue, and unknown origin.

The Stratton VA Medical Center has several oncology related specialty clinics that oversee the ongoing multi-specialty care and treatment for Veterans with cancer.



CANCER CARE & SUPPORT SERVICES

CANCER SURVIVOR'S CELEBRATION

Tess Thierbecker, LCSW, OSW-C

The Twenty Seventh Annual Cancer Survivors Celebration was held on Friday June 7, 2018. Approximately 200 cancer survivors, their guests and staff members attended the celebration of life that was held on the grounds of the Fisher House. The positive energy of the day was further elevated by the beautiful weather.

We remain extremely grateful for the support of Voluntary Service and Committee members. The dedication and generosity of our volunteers has been an invaluable contribution to this annual celebration.

The guest welcome was delivered by our hospital director, Darlene DeLancey, MS. The key note speaker Ret. Col., James McDonough the Director of the NYS Division of Veteran Affairs, spoke of the strength and determination of the veteran population and how that impacts the strength they show throughout illness. We also had a Cancer Survivor, sister of a veteran Sharon Malloy speak of positive attitude and grateful spirit contributing to emotional strength through treatment, and beyond.

We were fortunate to have the shared talents of John Dooley playing the bag pipes (including all charge songs of each branch of service!) as well as one of our own survivors, Richard Fournier, played Taps to honor the memory of those unable to celebrate with us.

Entertainment was provided by Bob Marcello an expressive performer drawing in the crowd to energizing singalongs. The colors were presented by the Boy Scouts of America Troop 502# Troy, New York.

Our partners at the American Cancer Society were in attendance. Many beautiful items were also donated by staff and volunteers that were used as door prizes.

Dr. Syed Mehdi our Chief Medical Oncologist delivered the closing remarks and highlighted the dedication and improvements in the cancer program throughout the past year. Our Master of Ceremony was John McDonnell, "Mac", who as always provides humor and organization to our events.

The VA Chaplain Service presided over the invocation and benediction. Pastries and coffee were provided by Voluntary Service. Volunteers helped with registration and distribution of VA Cancer Survivor T-shirts. A cook out was provided by Wal-Mart Distribution Center 6096, Johnstown, NY; we are extremely appreciative for their generosity for the *eighth* year in a row. The Johnstown DC 6096 staff have come to know our veterans and provided conversation, laughter and assistance with getting food to the table for Veterans to enjoy.

This event was successful because of the collaborative effort, support and involvement of many dedicated employees and volunteers. The planning committee is comprised of retired employees/veterans and personnel from various disciplines within the medical center. Their unselfish involvement is proof of their dedication to our Veteran patients.

This year's celebration was again a huge success. The planning committee is already looking forward to, and beginning to, plan for next year's event.

WOMEN VETERANS REPORT

Suzanne Deane, LCSW WVPM

The Women Veterans Program Manager (WVPM) along with our Women's Health Medical Director continue to support and advocate for women's health care and services at the Stratton VAMC facility and our 11 Community Based Outpatient clinics (CBOC's). The Women Veterans Health Committee, chaired by the WVPM, meets at least bi-monthly to address issues with our Women Veterans Program.

Darcy Janowski, NP is the designated Women's Health Primary Care Provider and she continues to have new female Veteran enrollees assigned to her patient panel so they can receive "comprehensive primary care" which includes their basic gender specific care. Women Veterans who were already assigned to other providers, who cannot provide this comprehensive primary care, are given the opportunity to switch to Darcy's panel.

The "Wellness Woman's Clinic" takes place every day for GYN except Wednesday which is a surgery day for our GYN provider. Women's primary care is open every day. Patients are seen either in the Women's Wellness Center to ensure that every woman can receive her basic gender specific care in a separate space designated just for women and from an interested and proficient primary care provider. Dr. Ikram who is a female primary care provider on the red team also sees women Veterans in the Women's Wellness Clinic one day per week.

Our GYN Provider Dr. Mesidor is full time with surgery time on Wednesdays. This gives our women Veterans a consistent provider face for primary care and GYN care in our Wellness Center. GYN Clinic is held every day except for Wednesday (OR day). There is also a GYN Surgical Care Coordinator who manages preoperative care for GYN surgical patients.

The current wait times for new and returning appointments in the GYN clinic is below 30 days. As our number of female enrollee's increases, clinic time will be expanded to maintain access of less than 30 days. Women can access Community Care for mammography if the VAMC cannot provide the service and/or the Veteran lives 50 or more miles from the facility. Same day nursing visits and urgent care scheduling is available.

The Albany VAMC GYN clinic offers a check in and waiting area. In the "Women's Wellness Center", The Women's Health Primary Care Provider and the Gynecologist work collaboratively in this unit to provide women's comprehensive primary care and GYN specialty care. Behavioral Health is available within the Women's Wellness Clinic area to provide same day access to behavioral health services. The Women's Wellness Clinic providers continue to screen all women Veterans who are seen for care for intimate partner violence (IPV) and can provide a warm handoff to the VA IPV Coordinator.

Thin Prep Pap tests with HPV testing are performed for cervical cancer screening. The GYN provider notes any pap tests that are positive and follows up as needed. The Women's Health RN Coordinator receives a monthly PAP report which is reviewed to ensure follow up appointment was made. Mammograms are ordered by Primary Care providers or the GYN providers for breast cancer screening. The Women's Health RN Care Coordinator provides tracking of cervical and breast cancer screenings as well as maternity care coordination for pregnant Veterans.

Patient education involves all staff in the Women's Health Clinics. Staff has use of the Veteran's Health Library, which offers a wealth of medical information to share with all Veterans.

Providers can send the Veteran to the Women's Wellness Clinic in Albany or have an e-consult set up for a telephone consult and our GYN provider will call and speak with the Veteran about the best choices for that Veteran. The clinicians are planning to begin to expand services offered through telehealth.

CANCER CARE COORDINATOR

Aimee Beal, RN and Cindi Anderson, RN

The Cancer Care Coordinator position was successfully implemented within the facility in April 2018. Since beginning in this role, Coordinators started training on the Cancer Care Tracking System (CCTS) and the Advanced Liver Disease (ALD) dashboard.

Cindi and Aimee have been incorporated in the High Impact Training (HIT) collaborative team to spread awareness about Hepatocellular Cancer (HCC) and began networking with other facilities for guidance on tracking program requirements.

Since program inception in April 2018, over 7000 radiology cases have been reviewed. 401 lesions (lung and liver) have been indexed. 287 of these cases have active work up in progress.

There is active collaboration between the coordinators and the Department of Radiology to streamline coding for capture in CCTS and LiRads utilization.

Discussion with Primary Care leads and Cancer Care Coordinators are underway to define roles and tumor tracking methodology.

Aimee and Cindi continue to attend virtual courses/seminars on Case Management, Advanced Liver Disease and HCC.

Cindi and Aimee volunteered to assist with Cancer Survivor Day.

They actively participate in the Albany Liver and Multidisciplinary Tumor boards as well as attending the downstate Liver Tumor Board.

The Lung Cancer Investigation consult template is being refined but consults will continue to be managed via team effort until full training is completed.

CHAPLAIN SERVICE

Bruce Swingle

Chaplain Service at the Stratton VA Medical Center affirms the following: By virtue of training and experience as pastoral care and health care specialists, chaplains are aware of the spiritual and moral dilemmas which often arise from the anxieties, problems and fears which accompany illness and disabilities. The chaplain provides the kind of religious ministry, pastoral care, or just emotional support that seeks to meet the needs of the whole person in his or her struggle for health and peace of mind. The chaplain is sensitive to the variety of religious, spiritual and cultural backgrounds of patients to whom ministry is provided.

A Welcome Space – On the eleventh floor of the medical center you will find our Catholic Oratory and our All Faiths Chapel. The Catholic Oratory is a faith-specific prayer room. The All Faiths Chapel is a religiously neutral area. Both locations are available to all Veterans, families and visitors as welcoming places of prayer, worship, or simple quiet reflection.

Palliative Care Program – Chaplains continue to serve as active members of this team. We join with other staff to provide holistic care for our Veterans and their families. It is our privilege to work with patients and families in exploring their own spiritual nature and resources for health, wellness and hope.

Bereavement Services – As chaplains we continue to express our care and hospitality for families through our active involvement in bereavement services. Through a letter of invitation families and friends are welcome to attend our quarterly memorial services. These interfaith services are held in our medical center's All Faiths Chapel. Families and friends are invited to honor their loved ones through words and participation in a ritual of remembrance.

Ongoing Integration – We continue our efforts to have Chaplain Service and spiritual support integrated into patient care. Chaplains coordinate the spiritual care of any Veteran within our facility who requests or desires such service. Through chaplain visits we can offer a formal spiritual assessment. Additionally, we provide emotional support and spiritual resources that are respectful of each Veteran's spiritual beliefs, religious practices, and personal values.

Spirituality is an important element in holistic care. For many people their spiritual beliefs, personal values and religious practices are vital resources for coping, addressing existential concerns, and in making decisions. It is our privilege as chaplains to step into the circle of care with Veterans and their families during this time in their lives.

HEMATOLOGY/MEDICAL ONCOLOGY REPORT

Syed Mehdi, MD

The Hematology-Oncology department continues to provide personalized medicine for our cancer patients. With a changing & challenging landscape in the treatment approach for patients with malignancies, the Hem-Onc providers keep themselves very updated by attending national conferences & discussions in the weekly tumor board.

The department consists of medical providers, oncology nurses, social worker, nutrition services, palliative care, oncology pharmacists and a certified tumor registrar. They all communicate very well on a regular basis. The infusion room nurses meet every morning to discuss all patients who will receive treatment that day. They all follow National Oncology Nursing Society Standards (ONS). They are the backbone in educating the Veterans and caregivers regarding the side effects of various treatments.

They are also involved in process improvement projects. They have successfully implemented a primary nursing care model for each patient receiving systemic therapy. Both Patty Minkler and Nicolle Martin are educators at a local Oncology Consortium. Nursing students from Russel Sage College rotate through our infusion room and gain experience from this devoted oncology nursing staff. All nurses maintain their ONC chemotherapy/biotherapy cards which positively impacts cancer care.

Our Research Coordinator Elisa Ball continues to assist us in enrolling in clinical trials.

The integration of nutrition, the oncology social worker as well as palliative care within Oncology clinic is indeed a blessing for veterans with cancer. They see all services in a single visit. This has resulted in much better symptom control and hence quality of life.

Our Certified Tumor Registrar, Bernice Williams, continues to perform an outstanding job assisting providers who are involve in cancer care with data gathering, auditing & analysis to ensure standard of care and evidence base guidelines are being followed.

Our multidisciplinary weekly tumor board conferences are educational and so are the liver tumor boards which have participants from not only from Albany but also Syracuse & Buffalo VAMC.

NUTRITION AND FOOD SERVICES

Regina Latourrette, MS, RD, CDN, CSO, CNSC

Nutrition and Food Services provides an extensive program including meals, nutrition assessment and nutrition counseling to meet the oncology patient's nutritional needs. The nutrition department recognizes that the nutrition needs of a patient during cancer treatment and recovery differ based on the type of cancer, the stage and treatment of the disease.

The Registered Dietitian (RD) works closely with a multidisciplinary team of cancer specialists which includes: hematology and radiation oncologists, surgeons, nurses, social worker, otolaryngologists and speech pathologists. The RD considers the intensity of certain types of cancer, side effects of cancer therapy and the patient's ability to eat when assessing nutrition status. The RD uses medical nutrition therapy which may include diet supplementation, tube feedings and counseling patients on ways to improve nutritional intake.

Staffing in the outpatient Oncology Nutrition Clinic was increased to 1 FTEE to meet the demands of the patient population. Consults are no longer needed so anyone can alert nutrition (including patients) and request that an oncology dietitian provide nutritional services. The Registered Dietitian completes a nutritional assessment. The assessment utilizes timely, pertinent information and compares gathered data to evidenced-based standards. Patients may require assessments and counseling in response to weight loss, compromised nutritional intake, or if they require a tube feeding formula or supplies or nutritional supplements. Counseling sessions include instruction on nutrition interventions to alleviate or minimize nutritionally related disease or treatment related side effects. A nutrition diagnosis is made identifying nutrition problems accurately and consistently. The RD works with the patient by refining or changing interventions to produce the desired outcomes. Per patient's request, family members can be included in nutrition clinic appointments.

This year, the Oncology Dietitians helped to plan and present at 2 lunch and learns. One topic was on Melanoma with 46 attendees and the other was on Lung Cancer with 60 attendees.

The Oncology Dietitians also completed a study of quality titled "Non-Compliance to Nutritional Recommendations as a Predictor of Weight Loss in Cancer Patients". As a result of this study, the Oncology Dietitians completed a process improvement project titled "Dietitians Trained in Motivational Interviewing to Improve Patient's Weight Status in Oncology Nutrition Clinic". The Oncology Dietitians utilized the VA's training system (TMS) to complete training on Motivational Interviewing. Because of the training in Motivational Interviewing the Process improvement project showed a 10% improvement by decreasing the amount of weight lost by patient during course of their oncology treatment.

The Oncology Dietitians also completed a quality improvement project titled "Management of Hyperglycemia in Patients Diagnosed with Pancreatic Cancer Who Are On PERT. A protocol was developed to monitor blood glucose and HA1C in those patients with pancreatic cancer who are receiving pert and alert their primary care and clinical pharmacist to the elevations in blood glucose.

One of the Oncology Dietitians also serves as the Out Reach Coordinator on the Comprehensive Cancer Committee. The other Oncology Dietitian acts as her substitute. The Dietitians are responsible for training Veterans who require a feeding tube as part of their cancer symptom management. The Dietitians develop a feeding regimen and provide the Veteran with orders for the formula and supplies needed to maintain their feeding tube.

**ADVANCED ILLNESS COORDINATED CARE (AICC) /
PALLIATIVE CARE CONSULT TEAM (PCCT)
Ishtpreet Uppal M.D.**

This has been an exciting year for palliative care within the VA system.

As a national healthcare system, there have been great strides in improving palliative and hospice care for our Veterans.

Here in Albany, we are proud to continue our active collaboration with the oncology team, now in its ninth year. The palliative care team continues to work closely both in inpatient and outpatient settings offering symptom management and emotional support for veterans with a serious illness to cope with everyday life.

In calendar year 2018, the palliative care team completed a total of 401 consults.

There were 150 completed outpatient consults with referrals from oncology, radiation oncology, ENT, surgery, urology along with chronic disease clinics.

There were 251 completed inpatient consults.

According to the Veterans Health Administration Support Service Center (VSSC), in fiscal year 2018, a total of 480 consults were completed with 413 unique patients across all completed Palliative Care Consultative Team (PCCT) consults.

In our oncology clinic, we saw a total of 576 appointments in calendar year 2018 with 163 unique patients.

With implementation of the Goals of Care Conversation (GOCC) project, in the course of fiscal year 2018, a total of 679 goals of care conversations were completed and documented.

426 of these were in the outpatient setting.

NP Susan Casler and Dr. Julie Phillips were able to complete 2 goals of care training sessions with the oncology staff during Tumor Board.

Another achievement for the Albany VA was in the bereaved family survey scores.

The FY17Q4-FY18Q3 overall score for Albany was 74 in comparison with score of 64 nationally.

In calendar year 2018, of the 331 Veterans who died with an oncology diagnosis, 33.23% died while receiving services from hospice.

Only 3.32% received chemotherapy within 14 days of death.

We remained VISN leaders in terms of access. Care Assessment Need (% CAN) 98-99 with Hospice Palliative Care as of Sept 2018 (Fiscal year) Albany had seen 27% versus the national average of 16%.

65% of Veterans had a palliative care consult >30 days prior to death (national average 43%).

The palliative care team remains dedicated to offering mindfulness strategies to Veterans in oncology for symptom management as part of our whole health/integrative care initiative.

The team also continues to do End of Life Nursing Education Consortium (ELNEC) training (an 8-hour class on End of Life Care for our nursing staff which is also offered to our Hospice/Veterans partners in the community).

Over the past year we have continued to participate actively in the Schwartz Center Rounds which allow a safe forum for discussion of patient care related issues with a tie in to compassion and self-care. This is valued by multiple interdisciplinary staff members as an important intervention to help cope with burnout and stress.

Presently the palliative care team remains comprised of a full-time registered nurse, a full-time nurse practitioner and a part-time (0.6 FTE) physician. Our interdisciplinary team also includes our Chaplain and

a psychologist (0.1 FTE). We work closely with Social workers from Oncology, chronic disease clinics and primary care. We are well integrated across multiple clinical settings in the facility.

The team participates in discharge planning and in case finding using well published defined criteria (Weissman DS, Meier DE. Identifying patients in need of a palliative care assessment in the hospital setting: a consensus report from the Center to Advance Palliative Care. JPM 2011 Jan; 14(1):17-23) to identify Veterans most in need.

If Veterans whom we follow in our outpatient clinic require hospitalization, our team continues to offer support and improve communication and engage in appropriate discharge planning.

We focus on management of a multitude of symptoms including pain, frailty and debility, mood, anorexia, anxiety, management of bowels, nausea, vomiting, and sadly, PTSD.

Our chaplain offers spiritual care for both existential suffering and emotional support. As our team longitudinally follows Veterans and their families with symptom management, we may participate in the care of both curable and incurable disease processes. If transition to hospice care is looming ahead, we serve as the “pre-hospice” service, seeking to fill the gap between the time of diagnosis and the ultimate referral to hospice.

In addition to helping Veterans and their families cope with their illness, our team also provides bereavement support. We regularly make bereavement phone calls.

Our nurse practitioner also participated in the training of the pharmacology PGY2 resident, adding a palliative care perspective as well as precepting a Sage Graduate School NP student.

In conclusion, for this remarkable year, would like to highlight an article published with data from the VA, which showed that Veterans with lung cancer who had at least one palliative care encounter after their diagnosis were 82 percent less likely to die by suicide. Donald R Sullivan et al. Incidence of Suicide and Association with Palliative Care among Patients with Advanced Lung Cancer, *Annals of the American Thoracic Society* (2018). [DOI: 10.1513/AnnalsATS.201805-299RL](https://doi.org/10.1513/AnnalsATS.201805-299RL).

SOCIAL WORK SERVICES **Teresa Thierbecker, LCSW, OSW-C**

The primary focus of the Oncology/Hematology/Radiation Oncology Social Worker is to provide psychosocial support and resource information to patients and families facing the challenge of cancer. Many of the cancer patients treated at Stratton VAMC have been served by social work. Patients and families are offered psychosocial support as they receive their diagnosis and throughout the course of and following treatment. They are also assisted in obtaining appropriate in-home and community services to enhance their quality of life.

The oncology social worker assists Veterans and their families in navigating thru the health care system and provides assistance and reinforcement surrounding their cancer diagnosis and education.

The oncology social worker also manages the distress screening tool provided to patients at initial consultation. Social work reviews all screening tools and provides follow up contact to those patients who identify needs or concerns. Further referrals are made based on the needs identified on the screening tool.

Emphasis is focused on providing patients and their families with supportive counseling and assistance with concrete, practical issues that arise during cancer care as well as in the last phases of life, such as

legal, financial, employment, and family concerns. Information and assistance is also provided to assist Veterans applying for eligible benefits, and/or assistance with the paperwork needed to take a leave of absence from work to tend to medical needs.

The Oncology Social Worker assists patients to meet the many challenges faced with End of Life Planning. Advanced Directives are discussed with Medical Oncology and Radiation Oncology patients. Paperwork is provided, explained and completed when the patient and family are prepared to do so.

Furthermore, assistance and linkage with available VA and community resources for those facing the imminent death of a loved one and/or resources for those who have recently lost a loved one is available to patients via the Oncology Social Worker. Ongoing social work involvement ensures the continuity of care in the provision of outpatient, inpatient, transitional, and hospice Services.

STRATTON VA & AMERICAN CANCER SOCIETY
Partnership Summary Report 2018
Joni Richter

Cancer Information & Patient Support Services

Referrals to ACS January – December 2018

Patients by Channel

800-227-2345	67
Local Office	28
Patient Referral Form	39

	# of Patients	# Provided
Service		
General		
Information/Personal Health Manager	67	67
SR Met w/Resource Referral	39	39
Support Group	4	4
Transportation	2	2
Hotel/Hospitality/Other	2	10
Reach to Recovery	2	2
Wigs	2	2

Highlights

In 2018, the American Cancer Society (ACS) continued their long - standing partnership with Stratton VA to support their efforts in meeting the Commission on Cancer (CoC) standards of the American College of Surgeons. The American College of Surgeons CoC standards aim to improve the quality of cancer care in the United States. We at the American Cancer Society are happy to partner with Stratton VA Healthcare System, as they have been a CoC-accredited program for 50+ years and are a valuable resource for Veterans and their families.

Part of this collaboration includes providing Cancer Resource Volunteers onsite, collaborating on annual cancer specific conferences for Veterans, staff and the community, and connecting cancer patients with local and national resources such as transportation, lodging, support groups, wellness programs, personal health managers, as well as other services available from the Society, local and national organizations, &

local hospitals. We are proud to say that our “Cancer Resource Connection” database, with over 85,000 resources is available free of charge on our website Cancer.org and that it contains thousands of local and national resources. We also make ourselves available to the public through this website and our National Cancer Information Center at 1-800.227.2345.

CLINICAL RESEARCH

Elissa Ball

A total of 45 subjects were enrolled to cancer related research studies in 2018.

The veterans previously enrolled into the CONNECT CLL Registry, INCYTE REVEAL Polycythemia Vera Registry, and the INCYTE MOST Myelofibrosis/Essential Thrombocytopenia Registry trials were followed as per their protocols. Twenty-nine veterans with previous diagnoses of cancer, actively being followed for their cancer, were identified as having enrolled in the VA Million Veterans Program in the first quarter of 2018. The Celgene CONNECT Registry trial was completed in March 2018. Three subjects were enrolled into the Janssen Telehealth Study and this study continues to actively recruit subjects.

Stratton VAMC Cancer Program initiated their participation in the VA Precision Oncology Program. A total of ten specimens were forwards to this program.

Three Veterans were enrolled in clinical trials at non-VA sites (Memorial Sloan Kettering Hospital and New York Oncology and Hematology).

COOPERATIVE GROUP STUDIES

Protocol # Title(s)

- Million Veteran Program: A Partnership with Veterans

INDUSTRY SPONSORED STUDIES

Protocol # Title(s)

- CONNECT: The Chronic Lymphocytic Leukemia Registry- completed 3/2018
- REVEAL: Prospective, Non-interventional Study of Disease Progression and Treatment of Patients with Polycythemia Vera in United States Academic or Community Clinical Practices- in long term follow-up
- MOST: Prospective, Longitudinal, Non-Interventional Study of Disease Burden and Treatment of patients with Low-Risk Myelofibrosis (MF)or High-Risk Essential Thrombocytopenia (ET) or ET Patients Receiving ET-Directed Therapy- continues in follow-up
- Observational Cohort Study of Patients with Castration Resistant Prostate Cancer (CRPC) “TRUMPET”- Active
- A Randomized Controlled Trial of AdV tk plus Valacyclovir Administered During Active Surveillance for Newly Diagnosed Prostate Cancer- Active
- Impact of Oral mCRPC Therapies Stewardship Pilot Program for Veterans (Janssen Telehealth Study)- active and enrolling

We were successful in achieving more than our required 2% enrollment for ACOS certification.

Information regarding clinical trials is available by calling or contacting:

Stratton VAMC
American Cancer Society
ClinicalTrial.gov

Elissa Ball 518-626-6447
1-800-4-CANCER

RADIOLOGY AND NUCLEAR MEDICINE
F.S. Santos, MM, MBA/HCM, RT (R) ARRT

Changes in medical imaging are driven by advances and innovations in technology. Improved and new technology allows further refinement of techniques in completing procedures in the diagnosis, staging, assessing response to treatment, and early detection of cancer. Well trained staff in Radiology and Nuclear Medicine offers several different types of imaging to serve our Veterans in Albany Stratton VAMC.

1. Nuclear Medicine- studies are performed from Monday thru Friday for Nuclear Medicine (NM) and PET/CT. Requests can be accommodated as soon as the next day if needed. Imaging exams help in assessing tumor activity, lymph node involvement, and metastases. Pre- and post- treatment scans can be performed to assess the effectiveness of chemo and radiation therapies. Specialized studies for lymphatic mapping, neuroendocrine tumors, assessment of pulmonary function and left ventricle function after procedures and therapy are also available. The department has a GE PET/CT camera with a 64 slice CT for attenuation correction; Siemen's Nuclear Medicine camera with a 16 slice CT for SPECT/CT imaging; low dose CT imaging is used in both NM and PET/CT for attenuation correction and fusion imaging for improved images. PET/CT imaging is also used in positioning treatments in coordination with radiation therapy and as part of treatment planning.

2. VIR – Specialized procedures, in addition to tumor ablation and chemo embolization, biopsy and localization of masses, continue to grow in the vascular and interventional radiology service line. The units have built-in safety and efficiency features that allow more imaging abilities utilizing lower doses of radiation. Smart masking allows contrast enhancement of structures by superimposition of reprocessed or prior images. The auto injector system monitors flow pressures and requires less overall contrast. Studies are available in-house 24/7, through VA interventional radiologists.

3. MRI – The MRI unit is due for replacement which will convert the current system to digital broadband MRI providing flexible and intelligent tools for faster scanning and better patient comfort. The upgrade not only increases system versatility but also helps patient flow and clinical performance for a variety of applications. Radiology has extended MRI scheduling for patient access. Routine appointments are scheduled weekdays. Emergency services are provided on an on-call basis outside of administrative hours.

4. CT – Radiologists review all CT protocols for dose optimization and better interpretation eliminating unnecessary scan phases and establishing scan start and stop locations to particular areas of clinical interest. CT uses image correction software and tube current modulation to reduce overall patient exposure while still producing optimal diagnostic quality images. This technology is particularly beneficial on multiphasic studies which intrinsically have higher doses. Doses are documented for patient safety and record. Urgent services are available in-house 24/7.

5. Mammography – An important and integral part of the Women's Health program for screening and diagnostic follow up care of breast cancer, mammography exams are scheduled five days a week, Monday-Friday. Advancements in technology allows for the various screening tools that administer lower doses of radiation and optimal imaging to improve diagnostic quality and patient's experience.

6. Ultrasound – Ultrasound is instrumental in early detection of masses and establishing its cystic and solid characteristics. Sonography continues to expand services to include vascular assessments and exams for other complications of tumors and its subsequent treatments. Routine appointments are scheduled from Monday – Friday and STAT studies and add-on requests are accommodated by extending hours and on call tech for off tours period.

7. Diagnostic Radiographs and Fluoroscopes – New radiography systems enable better diagnostic imaging and upgraded fluoroscopy allow efficient and effective studies in screening and following up

gastrointestinal and genitourinary tumors and other abnormalities. Two GE portable fluoroscopy C-arms with vascular angiography package enable capable intra-operative imaging support. Fluoroscopy exam doses are tracked and audited for safety and reported to the Radiation Safety Committee.

MAMMOGRAPHY REPORT

Linda Carpinello-Dillenbeck R.T. (R) (M) (ARRT) Quality Control Mammographer

This was our 24th year of fully accredited ACR & FDA /VHA mammography. This also was our third year of using The Hologic 2D/3D Hologic Genius Imaging System. In spring of 2018 we received dual 2D and 3D ACR Reaccreditations. This was a double American College of Radiology Reaccreditation. We received no corrective actions on our clinical imaging, and this is very difficult to achieve.

We had the pleasure of collaborating with QM Specialist Grace Keers and VHA National Mammography leadership.

We are members of the NYS Cancer Services Program of free mammography to underinsured community members. Early Detection saves lives and that is why leadership continue the employee & volunteer mammography free screening program as an employee perk that saves lives, and minimizes staff having to leave the campus to receive mammography imaging. We increased patient load, discovered more cancers (9 cancers in 829 patients) and were stewards of highly accredited 3D Tomo mammography at our in-house mammography center. We serve diverse male and female patients screening and diagnostic mammography. Our patient load is supported with tremendous clinical support from the Cancer Committee Dr. Mehdi and team, and Woman's Health Program. In September 2018 we rolled out the national woman's self-referral program that was led by Dr. Rachel Grimm, it is known as PTSD patient self-referral and the VHA mammographers are now given the permission to write orders for self-referring female Veterans. This offers a more streamlined scheduling process. We are honored to work with Suzanne Deane Woman Program Manager in our yearly Pink Out of lobby screening sign up event and interactive noon time clinical provider speaker's forum. In addition, we do outreach at the Woman Veteran's Health Fair. Linda is an American Cancer Society Volunteer when off duty who specializes in mammography outreach; as a result, she won an ACS 2017 Community Hero award presented by Joni Richter for Linda's partnership in supporting early detection, screening and ACS partnership with Stratton VA and our mutual local Veteran community in 2017.

PHARMACY SERVICE

David Kupiak, R. Ph

Members of the Hematology/Oncology Pharmacy Department continue to be actively involved in the care of our many Veteran patients. They serve as an authoritative information source on antineoplastic agents and on the many adjuvant and neoadjuvant treatment regimens. This would include, current dispensing practices and the proper technique for preparation of these medications within our sterile products mixing pharmacy. The pharmacists are supported by a team of technical staff specifically trained in the preparation, handling and dispensing of antineoplastic agents for various treatment regimens. Our pharmacy team also works closely with the hematology/oncology team to provide guidance, direction and oversight of Cancer Research Trials. Dave Kupiak R.Ph., Lead Oncology Pharmacy Program Specialist, along with a team of chemotherapy trained clinical pharmacists and technicians; contribute to the design, conduct and evaluation of pharmaceutical related treatment regimens. In addition, they participate in the evaluation and utilization of antineoplastic agents, under the auspices of the VHA Pharmacy Benefits Management Services, VISN 2 Pharmacy & Therapeutics Committee, Medication Use Committee, Quality Assurance, Cancer Committee, Tumor Board, Institutional Review Board and Research and Development Committee. Our treatment preparation pharmacy, within the 9th floor Cancer Treatment Center, has been under renovation and when completed, will be in full compliance with current Joint Commission

requirements for pharmacy areas preparing sterile chemotherapy products. This satellite pharmacy is under constant review to maintain the most up to date chemotherapy preparation standards. Planning has been under way this year for the implementation of a new round of practice standards that will become mandatory shortly. Those standards called USP 800 along with the current USP 797 standards, require that these updates and modifications be done to our current preparation pharmacy. This work is ongoing and is expected to be completed by the end of 2019.

Our pharmacists in addition to myself, Colleen Lowry PharmD, BCPS, Sterile Products Program Manager and Kevin Livingston PharmD, BCCCP, Clinical Pharmacist, participate in continuous training and continuing education. This ensures that our Veterans are receiving medications that are prepared following current guidelines, using properly trained and supervised staff.

RADIATION ONCOLOGY

Sudershan Bhatia, MD and Nicole Melius, BS RTT

The Radiation Oncology department at the Stratton VA Medical Center, Albany, NY is Accredited by the American College of Radiology (ACR).

We provide an essential treatment option for the care of Veterans diagnosed with various types of Cancer. Multidisciplinary treatment decisions are made in collaboration with our medical and surgical oncology colleagues.

From January 1, 2018 to December 31, 2018 there were 203 consultations and 157 patients received treatment. There were 185 CT simulations and 610 follow up visits during this period. The most predominant diagnosis treated was prostate cancer at 32%. The second most common malignancy treated was lung cancer at 19%, and third was Head and Neck at 13%. 81% of the patients were treated with curative intent and 19% with palliative intent.

Radiation therapy is a highly technology dependent specialty. We are one of the only two VAMC hospitals out of 40 Radiation Oncology centers with a Tomotherapy machine. All patients referred to Radiation Oncology are considered for treatment with advanced radiation techniques including: Intensity Modulated Radiation Therapy (IMRT), Image Guided Radiation Therapy (IGRT), Stereotactic Body Radiation Therapy (SBRT), as well as prostate seed implant brachytherapy.

Having installed the new TrueBeam linear accelerator, we will soon expand services further to include Stereotactic Radiosurgery (SRS) for brain tumors, SBRT for liver tumors. The SBRT prostate program is underway and the first patient has been treated. This will add convenience to eligible patients for highly effective short duration treatments.

Brachytherapy for prostate cancer is offered at our center and is performed with low dose rate permanent prostate seed implants. We are one of the very few Radiation Oncology programs in the VHA system to provide brachytherapy services. Our brachytherapy planning and delivery system offers state-of-the art treatment and delivery of precision brachytherapy for low and intermediate risk patients with prostate cancer.

We have two RN's who maintain and update all patient education materials. Social worker, Tess and Nutritionist, Regina and now also Andrea, who continue to provide excellent service to our Veteran patients undergoing treatment.

The departmental policies and procedures continue to be updated annually by our physics, dosimetry and therapy staff.

We are also actively involved with outcomes research to analyze efficacy of treatment outcomes to maintain quality assurance.

Our staff provides exemplary care to our Veterans. In addition, the staff continues efforts in teaching and research. Our staff mentors' short-term elective rotations for Albany Medical Center medicine residents. We continue to be a clinical education site of SUNY Upstate Radiation Therapy Technology students. The therapy students spend a semester in the Radiation Oncology Clinic and rotate through each area including treatment, dosimetry and nursing.

SURGICAL REPORT **Rebecca O'Malley, MD**

The Stratton VA Medical Center provides a wide range of surgical services in multiple specialties for cancer patients. They include general oncologic, hepatopancreaticobiliary, colorectal, otolaryngologic, urologic, and thoracic surgery services, as well a plastic surgery reconstruction service. In addition, robotic approaches to colorectal, pancreatic, and urologic cancers are currently available to our patients. Referral services include but are not limited to Pittsburgh VA Medical Center, Albany Medical Center, Albany Gastroenterology Center and the Woman's Breast Center at St. Peter's Hospital. Our surgical staff members have an active relationship with Albany Medical College and many hold academic appointments and/or dual appointments at Albany Medical Center. Albany Stratton VA staff actively participate in both internal and external continuing medical education activities and multiple surgical conferences by specialty at our own VA medical center, as well as at Albany Medical Center.

Our surgical staff members have attended and presented research at multiple nationally recognized conferences including; the Society of Surgical Oncologist Annual Cancer Symposium, the American College of Surgeons Clinical Congress, the American Urological Association annual meeting, the Society of Urologic Oncology annual meeting, the American Society of Colon and Rectal surgeons annual meeting, and the American Association of Plastic Surgeons annual meeting, among others. We regularly attend and moderate our weekly general tumor board meeting, our multidisciplinary liver cancer tumor board meeting and our biweekly multidisciplinary lung tumor board meeting at the Stratton VA as part of an effort to provide comprehensive cancer care for our VA patients. In addition, our surgical oncologist attends tumor board meeting at the Buffalo VA to aid in providing needed surgical care for patients with hepatopancreaticobiliary cancer.

The local surgical representative to the Cancer Committee is Dr. Rebecca L. O'Malley. She is a Board-Certified Urologic Surgeon who is fellowship trained in Urologic Oncology. In addition to being a full-time urologic oncologist at Albany Stratton VAMC, Dr. O'Malley also manages the urology division as section chief. She actively participates in research with recent publications related to decision-making and patient outcomes in kidney cancer.

The Stratton VAMC continues to provide a plethora of cancer-related surgical services, patient support and community outreach programs, as well as ongoing clinical research. All are considered central to the comprehensive care we aim to provide for our Veteran patients.

DENTAL SERVICE CANCER PROGRAM
Dr. Claudia Reyes-Lopez

The Stratton VA Medical Center Dental Service plays an integral role in the management of head and neck cancer patients. The three primary objectives of the Dental Service Cancer Program are:

- (1) To participate fully in-patient assessment and interdisciplinary treatment planning.
- (2) To establish optimum oral conditions for cancer therapy management.
- (3) To maintain effective recall for follow-up care of these patients.

Patients head and neck cancer patients are referred by consultation to the Dental Service. Each patient is assessed on an individual basis regarding overall systemic health, prognosis, oral health and motivation in order to develop a dental treatment plan which can be well integrated into the overall treatment plan (surgery, radiation and / or chemotherapy).

Early involvement of the Dental Service for evaluation and proper timing of any necessary dental treatment provides appropriate integration of medical/dental care, reduce management complications, and best serve the health and welfare of the patients involved. The goal for early dental intervention is to optimize the patient's oral health prior to surgical resection and/ or chemo radiation treatment.

All patients are instructed in proper oral hygiene. Radiation patients are placed on a fluoride therapy protocol. All head and neck dental cancer patients are seen during radiation therapy to screen for any untoward oral sequelae such as mucositis, xerostomia, loss of taste, and radiation carries. Patients who experience any oral sequelae to radiation therapy are appointed for follow up on a long-term basis. Considering this stringent follow-up program, very few cases of osteoradionecrosis have been reported at this center.

Any acute dental problems are best treated prior to surgical, radiation or chemotherapy treatment. Routine dental treatment is reinstated once the patient is ambulatory and comfortable following surgery, radiation and/or chemotherapy.

By assessing each patient in the pre-treatment phase, any necessary post-treatment prosthetic rehabilitation is facilitated, be it in the form of intraoral obturators, specialized prosthesis such as tongue bulbs or extra-oral facial prosthesis.

The annual survey was conducted of head and neck cancer patients identified during the 2018 calendar year based on data obtained from the Stratton VA Medical Center Tumor Registry. The purpose of this survey was to determine the percentage of patients identified with head and neck cancer that were screened, treated and/or followed by the Dental Service and/or referring VISN 2 Dental Services. The integration of CPRS (the VA computer patient record system) across VISN 2 allows us to view dental notes from other sites in our network.

The Dental Service receives consultations generated by the Head and Neck Pathway. The referring services send these patients to Dental Service for supportive care on a prn basis. Dental Service is represented at Tumor Board; consultations get generated on newly identified head and neck patients.

An interdisciplinary continuous quality improvement team had developed a Head and Neck Clinical Pathway to insure timely notification and consultation with respective services. However, this pathway is set to notify us on presentation of a T2 or greater lesion. We also depend upon ENT to set the clinical pathway in motion.

Our examination rate of head and neck cancer patients has been as follows:

Calendar year	2006	28/30	93%
	2007	34/39	87%
	2008	24/25	96%
	2009	25/30	83%
	2010	28/29	97%
	2011	34/40	85%
	2012	24/28	86%
	2013	14/16	87.5%
	2014	20/23	87%
	2015	17/28	60.7%
	2016	22/30	73.3%
	2017	17/23	73.9%
	2018	13/18	72.2%

The data was integrated into a table for an overview of patients identified and screened during 1983 – 2018. The data reflects a continuous and consistent effort for improvement with respect to the multidisciplinary approach regarding the management of head and neck cancer patients. Tables have also been developed to illustrate the numbers of patients diagnosed by the site at the Stratton VA and numbers of these patients screened and/or treated by the Dental Service during 1983 - 2018. The Stratton VA Medical Center Dental Service plays an integral role in the treatment of such patients.

In 2018, 13 out of 18 patients were seen by the Stratton VAMC Dental Service. Of the five patients not followed/cleared by the Dental Service, one refused cancer treatment here at the Albany VA and preferred to go to Florida for treatment. Two patients expired. One was a Syracuse patient without dental consult and another one is an edentulous patient without a dental consult. Cancer incidence by site of those not followed/cleared include: 3 oral cavities (1 floor of mouth and 2 tongue), 1 hypopharynx and 1 larynx (glottis). We will continue to encourage the multidisciplinary treatment approach for head and neck cancer patients.

HEAD AND NECK CANCER PATIENTS 1983 – 2018

Tumor Site	Number of Patient Identified	Number of Patients seen by Dental Svc.	% of Patient seen by Dental Svc.
Tongue	213	189	88.7%
Salivary Glands	13	9	69.2%
Gingiva	20	17	85.0%
Floor of the Mouth	103	95	92.0%
Other Mouth	111	102	91.8%
Oropharynx	218	204	93.5%
Nasopharynx	40	37	92.5%
Hypo pharynx	142	127	89.4%
Nasal Cavity	45	41	91.1%
Larynx	495	422	85.2%
Total:	1400	1243	89.0%

**HEAD AND NECK CANCER PATIENTS
SCREENED AND/OR TREATED BY DENTAL SERVICE
1983 – 2018**

	1983-87	1988-92	1993-97	1998-02	2003-07	2008-12	2013-17	2018
Tongue	39	31	30	25	24	12	24	4
Salivary Glands	0	9	0	0	0	0	0	0
Gingiva	1	5	2	4	2	2	1	0
F.O.M.	24	22	20	13	9	5	2	0
Other Mouth	27	18	14	14	14	7	7	0
Oropharynx	21	38	28	29	31	41	15	1
Nasopharynx	6	11	4	5	7	3	0	1
Hypopharynx	35	25	26	11	12	12	5	2
Nasal Cavity Sinuses	6	13	2	4	9	5	1	0
Larynx	77	86	70	63	45	46	34	5
Total:	236	258	196	168	153	109	89	13

**HEAD AND NECK CANCER PATIENTS
1983-2018
INCIDENCE BY SITE**

	1983-87	1988-92	1993-97	1998-02	2003-07	2008-12	2013-17	2018
Tongue	41	35	33	29	24	14	31	6
Salivary Glands	0	13	0	0	0	0	0	0
Gingiva	1	5	2	4	2	3	1	0
F.O.M.	25	22	20	15	9	5	4	1
Other Mouth	27	21	15	17	16	7	7	0
Oropharynx	23	39	29	31	31	44	20	1
Naso-pharynx	6	11	4	8	7	3	0	1
Hypo-Pharynx	36	25	27	14	15	16	6	3
Nasal Cavity Sinuses	6	15	2	4	9	6	3	0
Larynx	89	90	77	77	55	54	47	6
Total:	254	276	211	199	168	124	119	18

A Physician's Cancer Journey **By Eina Fishman, MD**



On September 11, 2001, I was the Chief of Staff of the Stratton VA Medical Center. No one will ever forget that day. America was attacked. Everyone was scared, anxious, but ready to meet the challenges of the day. We prepared our hospital for the wounded that never came. We supported each other and mourned and healed together. Fast forward 17 years later.

September 11, 2018, brought me unfathomable news – you have cancer. What??? How??? Why??? I was scared, and anxious. I never smoked, didn't drink much (I do love my wine with dinner), exercised regularly, ate healthily, no family history, and there I was – overnight an inpatient with metastatic lung cancer. Struggling to breathe and struggling to understand. How could this be happening to me?

Three weeks earlier I was flying from state to state on business and started feeling a little tired and short of breath. I went to the doctor, had a chest X-Ray, which was essentially normal, and treated for possible pneumonia or bronchitis. Three weeks later I was feeling worse. Another chest X-Ray revealed catastrophic findings. My entire right lung was collapsed under fluid from a tumor. I would not have believed it if I hadn't seen it with my own eyes.

The fluid was tapped (removed) and it was bloody. I knew in my heart that it was cancer. Sometimes having knowledge hurts. A CT scan showed bilateral pulmonary emboli (blood clots in both my lungs), massive pleural effusion (fluid on the lung) and a large tumor in my right lung. The hospitalization was rapid fire – biopsies, bronchoscopy, blood work, consultants, draining more fluid. I couldn't breathe without oxygen. Would I even go home? Waiting. Waiting. Finally, confirmation – metastatic non-small cell carcinoma of the lung. I was one of those lucky 15% who have no risk factors for lung cancer and are diagnosed with stage 4 disease. Upon diagnosis, the cancer was already in my lymph nodes and liver. I was so happy it hadn't spread to my brain or bones.

Being an inpatient was an interesting experience. First, I had no control over what was happening to me. I knew what should be happening, and mostly it went as expected, but not always. I had to keep reminding myself to be a patient and not in control. Tough for a doc with control issues. Take home message number 1 – everyone needs an advocate – to ask questions, to promote treatment, to ensure effective care. Even as an informed consumer, I did not have the ability to advocate for myself since I was so sick. Thank God for my family.

Second, people make assumptions. I don't smoke, never did. But once they heard I had lung cancer, the question they asked was "How long did you smoke?" the answer – Never. This made people very uncomfortable. They also assume as a doctor you know everything. I know a lot, but not everything there is

to know about metastatic lung cancer and possible treatment plans. Please educate me like everyone else. Don't assume anything.

Third, the most valuable quality I treasured was empathy and honesty. It doesn't take much to be empathetic. Try it. It goes a million miles toward rapid healing, and the lack of empathy can profoundly affect an ill, overwhelmed person. Honesty is important. What I don't know I can't manage. Don't make light of my situation or minimize the issue. This is a life and death battle. I need accurate information to help me succeed and fight.

Fourth, be there for your friend or family member. You don't have to say anything. You don't have to make promises you can't keep. Just be there. Isolation and abandonment are killers. I have a wonderful family and friends who have helped me immeasurably along the way, but I see many others who are hurting from the pain of loneliness, depression and isolation.

Going home was wonderful. But nothing was the same. I couldn't sleep on the bed due to shortness of breath. I couldn't walk very far. I couldn't do basic daily activities. I was tied to an oxygen tank. The emergency department was my second home with several complications and problems. It was very humbling to go from being the Chief Clinical Officer of a regional health plan to a disabled woman with cancer.

So, I learned to be kind to myself. This is a different life. A second chance to slow down and be thankful for each day. Enjoy the sunrise and the sunset. Appreciate the flowers and the rain, the sun and the stars. Value friendships and family. Be here now. None of us knows what tomorrow will bring. Enjoy today, and every day, the best you can.

Celebrate the small stuff. One more day alive is another day in paradise. Focus on yourself and what you need to do to get healthy. No one else can understand your body's physical and emotional needs better than you. Don't feel guilty for doing the things you need to do to get healthy. No apologies needed. You must be your own number one priority.

Be discriminating. Everyone will have a cure for your cancer. Most of it is well meaning but unscientific and unproven. Don't do anything to undermine the things you know work. Focus on the positive and the future. Make informed decisions with your care team and your support system. There are no right or wrong decisions.

Make your mental health a priority. It is normal to be depressed, anxious, sad, frustrated, sorry for yourself. But don't let these feelings overwhelm you. Manage them with support, talk therapy, even medication – whatever it takes to get healthy.

I eventually was able to wean off oxygen, and I was treated with a new drug called Tagrisso (Osimertinib). This new category of drug specifically targets certain genes that are found on the cancer cells. After 3 months, the lung tumor shrank dramatically, lymph nodes were smaller, and the liver lesion could no longer be seen. However, after 6 months, Tagrisso failed to prevent metastases to my bone. The cancer was growing and spreading. Although I felt better, the cancer was winning. I had a short course of radiation therapy for a lesion in my rib that was causing a lot of pain. It helped tremendously. The other bone lesions are not causing significant pain yet, so I have chosen to hold off on further radiation. I also started on chemotherapy, and continued Tagrisso, as the liver lesion was still hidden, and the lung tumor was unchanged. I am hoping that this combination helps reduce the spread and gives me a great quality of life. I have not given up the fight yet. New drugs come on the market regularly, and hope springs eternal.

September 11, 2019 brought the one-year anniversary of my diagnosis, or as my daughter calls it, my cancer anniversary. In the beginning, I didn't think I would survive this long with such an aggressive cancer.

But I did! And I hope this will be the first of many anniversaries. I am doing well despite further spread – new lymph nodes and another liver lesion.

Even two years ago, without the new therapies, I would have already died. I am grateful to be alive during a time of ongoing research and treatment options. The future is truly here. I am indebted to my teams for the support and opportunities I have had.

When I started medical school in 1978, having cancer was a death sentence. We had 3 chemotherapy drugs. No MRIs. No PET scans. No proton therapy. No targeted therapy. No immunotherapy. Almost no tools to treat cancer.

Today, cancer is becoming a chronic illness that can be treated and managed.
I am lucky that I have access to a wonderful family and support system.
I am lucky that I have a team treating me that has so many tools in the toolbox.
I am grateful that I do not have brain metastases.
I am grateful that I can enjoy my life one day at a time.

Thank you all, and may God Bless you all. My hope and prayers are for all of you to have peace, health and happiness.

Veteran's Cancer Journey: A wife's memory **Christina Knoll**

Halloween was a special time for my husband "Tom", as he liked to be called. This year his table was set up in the driveway, surrounded by candle lit pumpkins, a large bowl of candy in front of him, he expected many ghosts and goblins and as always, they came.

We were visiting our daughter in New York who stated, "you are yellow Dad, do you feel ok?" to which he responded, "no, I feel like ..." The trailer was unhooked, and we went to the emergency room at the VA hospital in Albany. It didn't take long for a diagnosis of pancreatic cancer and he was admitted. His only question was: "how long?" The answer was: "5 years if you are lucky."

We decided to move back to New York and the new house became a beehive of activity. Since nobody knew what Tom would be able to do after surgery and treatments, friends from Arkansas, our son and wife, Tom's sister and husband, all took turns to come and help. Among other things the whole bathroom was ripped out and redone the day before Tom's surgery, at 5 a.m. the water was turned back on and no leaks!

The day of the surgery my daughter and I spent in the waiting room. Hope, fear... a lot of time to ponder life, past, present, and future...

As the incision was healing 6 large bumps formed on his abdomen. They became affectionately known as his "6 pack". Tom started a 5 day -a -week routine of radiation oncology treatments accompanied by chemo therapy administered by pump for 6 weeks. Dr. Belgam, at the VA, would tend to the radiation treatments. Since Tom had several times the need for radiation, weeks at a time, we saw a lot of him too and built a great relationship. It was sad when Dr. Belgam left the area. Tom also appreciated the visits he received from Father Joe Grasso, the VA Chaplain. His care and compassion was of such help since Tom knew exactly what he was up against. My husband was rarely an in-patient, but Father would find him in the infusion suite, to chat, to bring him the sacraments.

Throughout his many courses of treatment, we did some wonderful living. In December we attended a wonderful concert by the "St. Petersburg Men's Ensemble. In January there was "The Fiddler on the Roof" at Proctors Theater. Our youngest son had re-joined the Navy and was graduating from OCS in Newport, R. I., we (Tom, our daughter, husband and I) met up with his wife, her family, and a number of mutual friends and were able to spend a few days there, attend the ceremonies, sail an evening on the "Rumrunner", walk about town, it was very enjoyable.

Tom had the pleasure of walking our daughter down the aisle at her wedding we had arranged a dinner cruise on Lake George and Tom danced the night away. He loved it!

The following month we were able to travel to Arkansas where Tom caught a 38 lbs. Kentucky Striped Bass in Lake Ouachita. In late November we spent Thanksgiving in California with our son.

Over the next few months Tom had to resume treatments, Tom worked closely with Dr. Mehdi to receive his cancer treatments, but he was not always strong enough to receive them. After a long winter of treatments, we took a trip to Florida and ended up in Key West! Although we wanted to spend time with our son in South Carolina, we had to report to the South Carolina VA as Tom had cellulitis in his neck. We called Dr. Mehdi in Albany and headed home. After a diagnosis of "cellulitis" we headed back home, contacting Dr. Mehdi along the way. Tom was admitted to the Stratton VAMC upon his return. Dr. Mehdi suggested that it was a case of "Gemcitabine induced radiation recall", a relatively rare side effect of the chemo therapy, however Dr. Mehdi had seen, researched, and treated several similar cases. He had also co-authored a paper on this condition. Once Tom was feeling better, we traveled to New England for a fall trip with friends from Arkansas.

Tom had to go back into surgery as it was time to deal with that "six pack". Unfortunately, it got infected and was a longer recovery than we had hoped but Tom walked every day to maintain his strength.

After a short trip to South Carolina to celebrate our son's promotion, we traveled to Russia. We explored Moscow and the small towns surrounding it. We saw museums and monasteries by cab, some walking and by horse drawn carriage. Then off to Voronezh on the overnight train. By morning we arrived. We were not aware that the city was celebrating their founding by Peter the Great. There were celebrations on every intersection, and performers from all the outlying areas, just amazing. Checking into the hotel we were told of a concert that evening by the Cuban Cossacks, known to be the best. What a performance! What voices! Dancing, nonstop, breathtaking! Fireworks afterward. Thousands of people out in the streets afterward, talking, singing, laughing.

After a day off for some needed rest and we took the SapSan, the bullet train to St. Petersburg, smooth and fast, a little pricier, but what an experience, especially for Tom the railroader. All good things come to an end. The SapSan hurried us to Moscow, another day of rest and it was time to say, "thank you for a marvelous time" to our friends and "good bye".

We arrived in New York and Tom gladly accepted the wheelchair he had refused when leaving. He did not feel well when we arrived home. But after resting several days, we set off for Maine, whale watching was something he wanted to do, there had been some great sightings from Bar Harbor. Unfortunately, by the time we arrived the whales had left for warmer climates. But it was nice, the weather great, we went for a long walk in Acadia Park, which for whatever reason, was closed. To celebrate our daughter's birthday a long weekend was spent with her and her husband at Sturbridge, in a haunted B&B. That too was fun.

Meanwhile Tom had routine labs and a CT scheduled and it showed a blood clot in the lung. Now we added blood thinners to the list, more injections. I guess we had been too lucky for too long. But not all was lost! It was detected, it could be treated. And we left for Beaufort, S.C. to meet our baby granddaughter, and celebrate our son's birthday, a week later we returned to ice and snow.

Things were quiet during winter, the normal number of medical check-ups, but Tom got restless in the middle of February. He caught a flight to Florida to visit his sister and her husband, they all had a grand time and returned 10 days later. We had to travel to Buffalo, NY to meet up with our son, wife and baby for the little one's baptism, there also would be a dinner for family and friends.

Tom started to feel uncomfortable even trying to lie down. Travel became limited. Therefore, we were welcoming a steady stream of visitors from across the country. Tom had quite a bit of family and friends in Western NY, in Arkansas, and then the friends of our son who, as children had spent much time at our home, and saw us as second parents. For many weeks there was always somebody or several, to spend the weekend with us. And Tom was so glad to see them. Our son visited in December. He had orders for Spain and would be leaving right after New Year. He came whenever he had accumulated a few days of leave, the last time had been in August with the baby.

Then came March. Tom was depressed, snow and cold outside, he craved green grass and sunshine, and insisted on taking a trip south, to Florida to his sister. After a few days visiting, we continued to Gulfport, MS, to call on our daughter-in-law and the baby granddaughter, from there to Texarkana and De Queen, AR. for the weekend. On to Little Rock, one fishing trip, a short one only. He hooked a small bass in Eric's pond, in the place where he caught his first Arkansas fish, he also caught his last. After seeing our closest friends, we left for Buffalo, he wanted to visit his parent's graves, we did not stop to see anybody else; we knew they would come to us.

But again, he had accomplished what was important to him. Then we had the difficult conversation about the fact that everything that could be done, had been done. And we were now entering the final phase.

After Easter the visits increased. May was buzzing with activity. Our son came on emergency leave, his wife and baby had just arrived from Gulfport, Tom's family, in-laws, our closest friends were coming and going, literally in shifts. We did a charter fishing trip on Lake George, it was a fine day except the fish weren't too hungry yet. Our son caught a keeper, a lake trout, but Tom enjoyed it all very much. He loved fishing but it seemed very difficult to find wheelchair accessible fishing spots in this area.

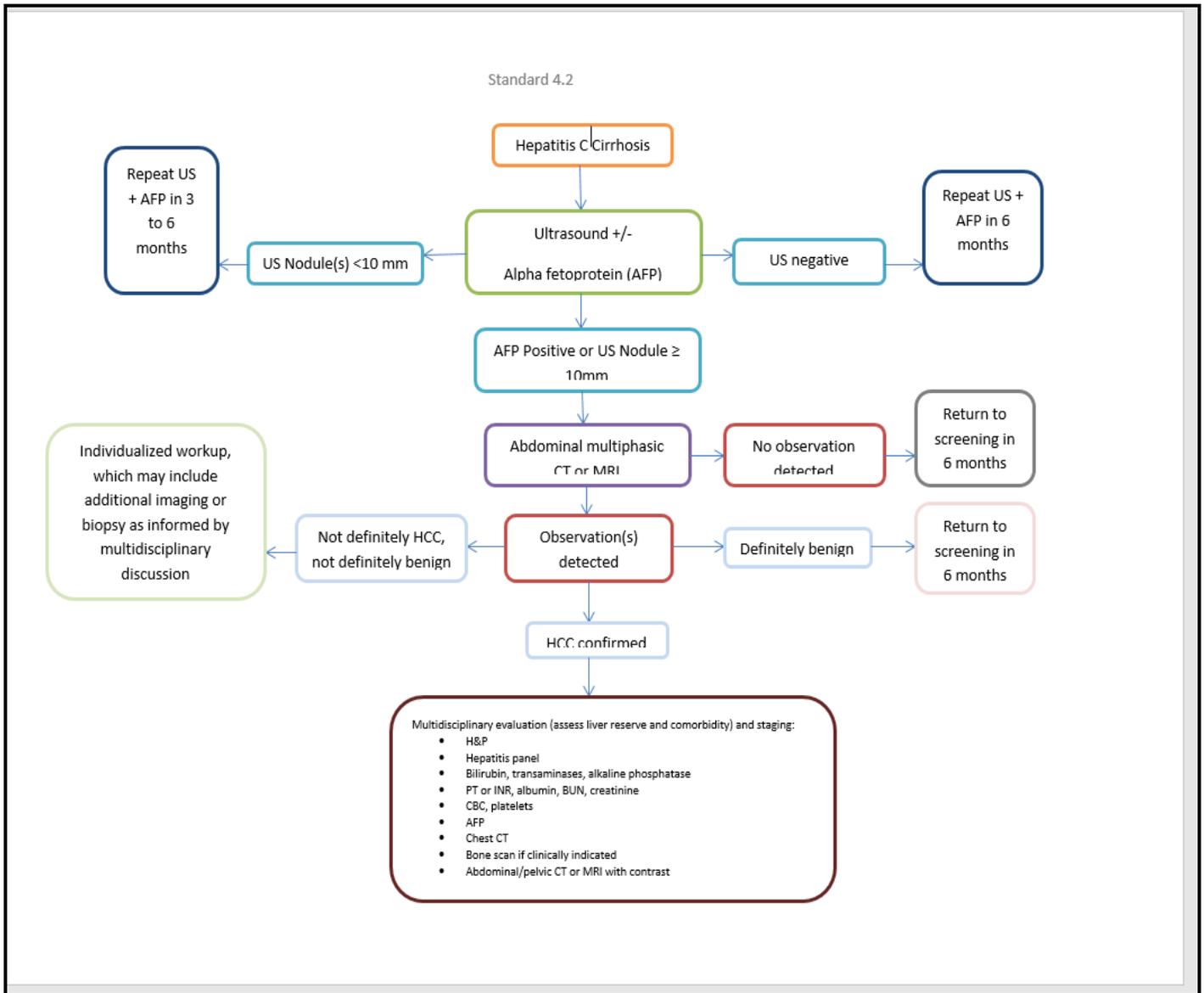
We celebrated our 50th wedding anniversary together with our son and his little family and of course, our daughter and husband. The day after our son had to leave again. We took him to the airport. He and his father would never see each other again in person.

For another month there were appointments and visitors. Tom's nephew and wife were the last to visit and to take him fishing, as they had done several times before. Our daughter spent all her waking hours with us, then stayed around the clock.

It was now June. Hospice came to do the intake and provide O2. The next day our very kind parish priest came to visit again and bring him the sacraments. That night he passed away. It was 4 years and 8 months after receiving the diagnosis.

Requiescat in pace! Memory eternal!

STANDARD 4.2 Screening Programs – Hepatocellular Cancer flow chart



PANCREAS CANCER

Maithao Le, MD

Standard 4.6

Pancreatic Cancer accounts for 3% of all cancers in the United States and is an aggressive cancer that has very few symptoms until the cancer is advanced. Symptoms may include abdominal pain, weight loss and diarrhea. Treatment includes surgery, chemotherapy and radiation.

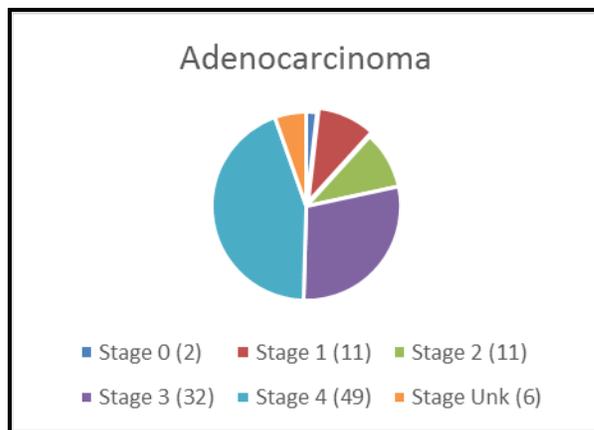
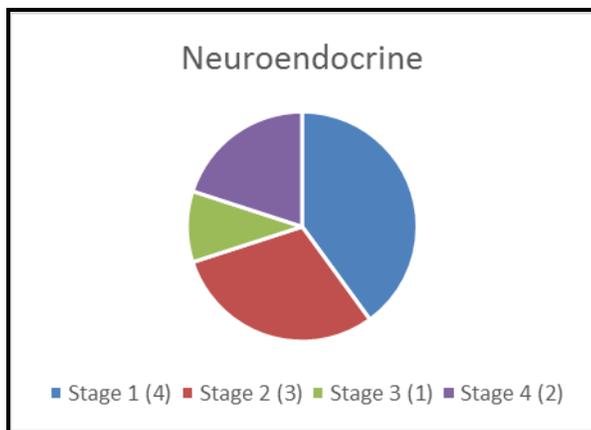
Some risk factors include smoking being overweight/obese, diabetes, chronic pancreatitis, exposure to chemicals, age (2/3 people diagnosis are > 65-year-old), male gender.

We analyzed our data for Pancreatic cancer from the years 2007-2017 at the Stratton VAMC. There were a total of 122 cases.

Pancreatic cancer is slightly more common in men than women, usually occurring after the age 45. Pancreatic cancer is classified according to which part of the pancreas is affected: the part that makes digestive substances is considered exocrine. The part that makes insulin and other hormones is considered endocrine. Although there are several different types/histology's of exocrine pancreatic cancer, 95% of cases are due to pancreatic adenocarcinoma. The exocrine pancreas makes up 95% of the pancreas, so it's not surprising that most pancreatic cancers arise here. The other cells of the pancreas that make hormones and released directly into the bloodstream (endocrine system) are called pancreatic neuroendocrine tumors or islet cell tumors. I have broken down the cases by neuroendocrine and adenocarcinoma.

Pancreatic neuroendocrine tumor: 11 patients (9%)

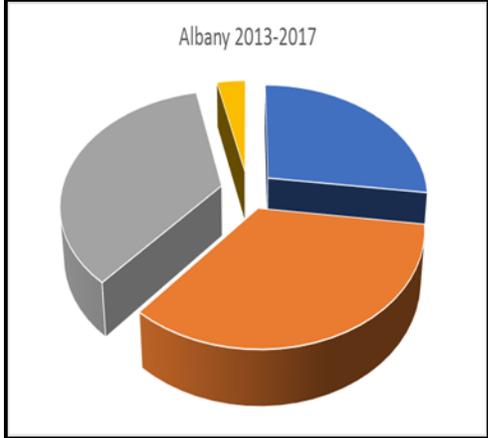
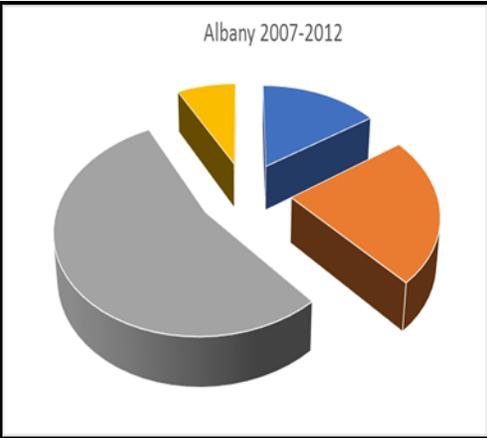
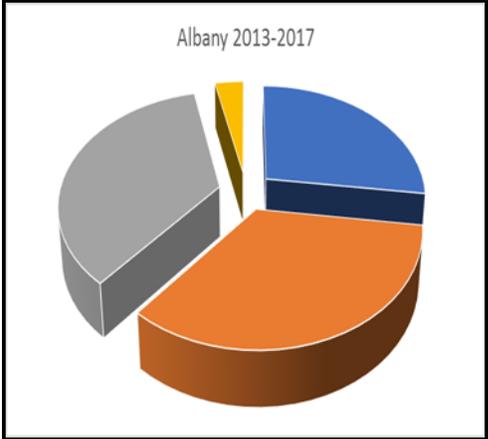
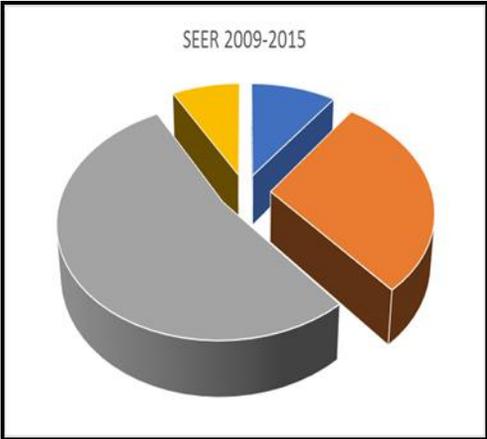
Pancreatic adenocarcinoma: 111 patients (91%)



Treatment:

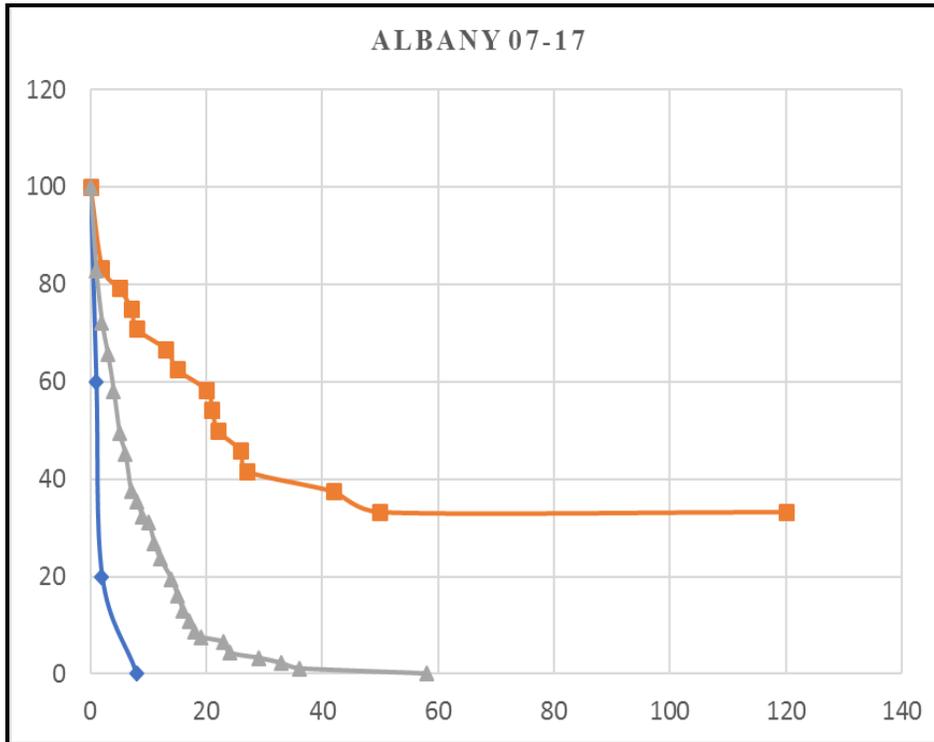
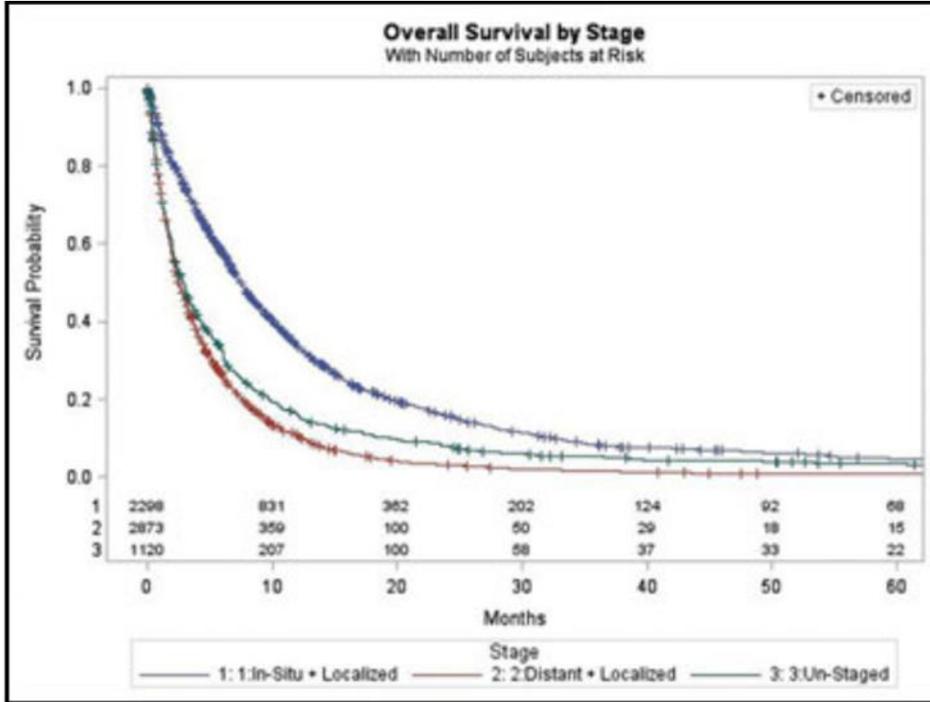
- None: 37 pts (33.3%), of these, 27 are stage 4, 5 are stage unknown
- Combination of Surgery/Chemo/Radiation: 74 pts (66.7%)
- All were appropriately stage and treated per NCCN guidelines.

Pancreatic Adenocarcinoma – Stage Distribution



 Local  Regional  Distant  Unknown

Pancreatic Adenocarcinoma – Survival



Unknown



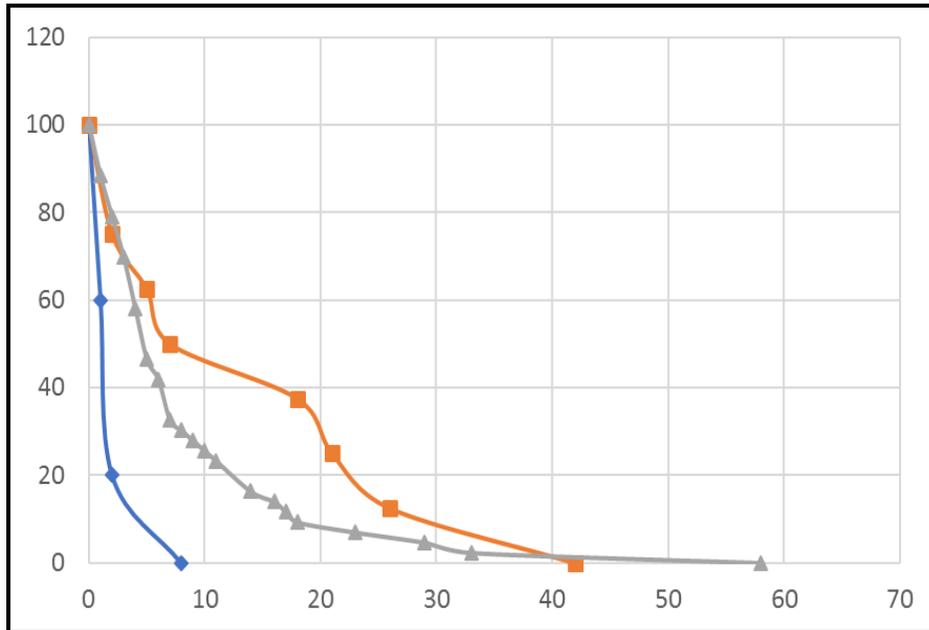
Loco-regional



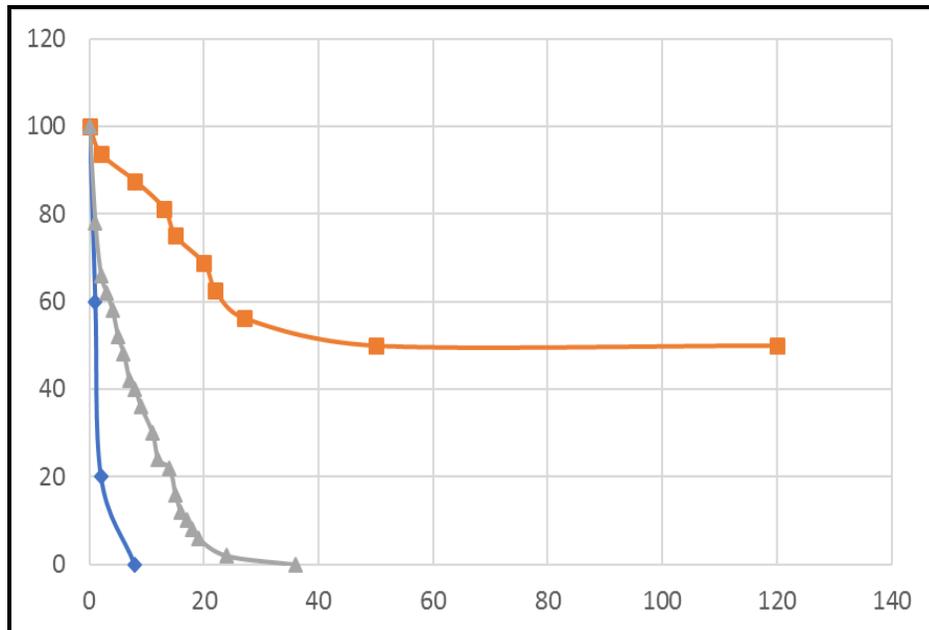
Distant

Pancreatic Adenocarcinoma - Survival

ALBANY 2007-2012



ALBANY 2012-2017



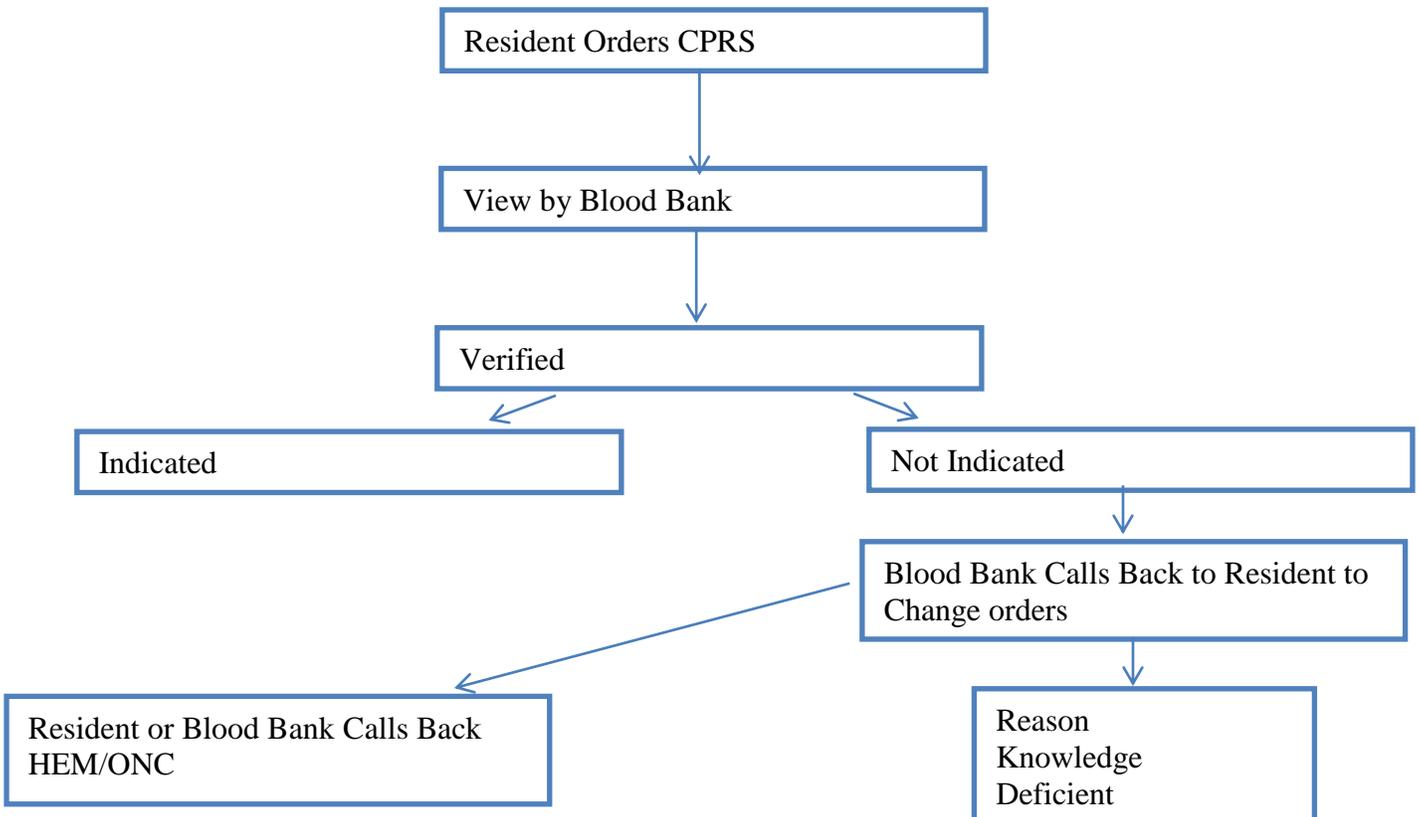
Standard 4.7 Studies of Quality: Patricia Minkler, RN

Definition: Each Calendar year, the cancer committee, under the guidance of the Quality Improvement Coordinator, develops, analyzes and documents the required number of studies, by category*, that measure the quality of care and outcomes for cancer patients.

*VACP Category: 1 Study of the quality of care and cancer outcomes; 1 program-defined study or study of quality defined at the VISN or regional level.

Must indicate the study topic that identifies a problematic quality-related issue within the cancer program: Knowledge deficit related to ordering blood products and specific requirements, e.g. CMV irradiated product, premedication's, transfusion threshold criteria, etc.

- **Define the criteria for evaluation, including data needed to evaluate the study topic or answer the quality-related question:** Blood bank data, chart review, retrospective review of denied orders.
- **Conduct the study according to the identified measures:** On Thursday 3/1/18 an interdisciplinary group met (Dr. Pasquale, Patty Minkler RN, Sue Fabiano Data Specialist, and Heather Merkley-Tamborello Manager Blood Bank) to discuss current practice problems. Anecdotal reports identify there is a perceived knowledge deficit related to ordering blood products. Medical and nursing staff question if specific requirements are needed (e.g. irradiated products, premedication, etc.) when ordering and administering blood products. Also, the blood bank is inconsistent related to answering questions and refers to the Hematologist. No data exists related to staff questioning regarding blood products. The plan includes for Sue Fabiano to conduct a retrospective chart review of rejected blood bank orders. Review of the data will occur post chart review.
- **Prepare a summary of the study findings**



Month	Requests	Product	Ordering staff
March	3	Irradiated blood, CMV negative versus safe	2 different residents
April	8	Irradiated blood, CMV negative versus safe	4 different residents
May	6	Irradiated blood, CMV negative versus safe	Medical Residents
June	4	Irradiated blood, CMV negative versus safe	Medical Residents

Concurrent data indicated 35 % of residents were unsure of blood component requirements when ordering transfusions.

- Compare data results with national benchmarks or guidelines**
 AABB and ASH Guidelines established. Present practice inconsistent with established guidelines. Residents are inconsistent when ordering blood products. Specific instructions regarding ordering blood components and transfusion specifics are not well understood by staff.
- Design a corrective action plan based on evaluation of the data**
 Based on review of the data a knowledge deficit related to blood product specific requirements were identified. The action plan to address the knowledge deficit includes but is not limited to development of a power-point educational presentation, dissemination of the ASBP (Armed Services Blood Program) and AABB pamphlet, and multimodal education for all staff including but not limited to physicians, nurses, blood bank staff.

Association of VA Hematology/Oncology (AVAHO) poster presentations

Colon Cancer Survival in the United States Veterans Affairs by Race and Stage (2001-2009)

Publish date: September 13, 2018

Author(s): [Azar I.](#), [Esfandiarifard S.](#), [Sinai P.](#), [Khreis T.](#), [Mehdi S.](#)

Background: CONCORD is a global program for worldwide surveillance of cancer survival. A recent analysis of the CONCORD-2 study shows a 9-10% lower survival rates for blacks affected by colon cancer (CC) as compared to whites in the US between 2001 and 2009.

Methods: We aim to investigate the differences in the survival of blacks and whites affected by CC in the National VA Cancer Cube Database in the same time-period. Overall, 30,196 CC cases between 2001 and 2009 were examined.

Results: 66.12% (19,967) of CC patients identified as white and 16.32% (4929) identified as black. The distribution of stages in blacks was the following: Stage 0: 10.49% (517), I: 25.10% (1237), II: 18.58% (916), III: 17.73% (874) and IV: 17.91% (883). By comparison, CC cases in whites presented as Stage 0: 8.92% (1781), I: 26.62% (5316), II: 22.29% (4450), III 18.75% (3744) and IV 13.71% (2738) (P value for X2 trend test = .021). Interestingly, in contrast to the results of the CONCORD study, the overall 5-year survival for all stages of CC in blacks and whites was similar [blacks: 2,854 (57.90%); whites 11,897 (59.58%); P = .2750]. The same holds true for the 5-year survival for Stage 0 [blacks: 423 (81.82%) whites: 1391 (78.10%); P = .5338], Stage I [blacks: 932 (75.34%) whites: 3973 (74.74%); P = .8667], Stage II [blacks: 605(66.05%) whites:2927 (65.78%); P = .9427], Stage III [blacks:509 (58.24%) whites:2138 (57.10%); P = .7513], Stage IV blacks:101 (11.44%) whites:364 (13.29%); P = .2058].

Conclusions: The racial disparity in survival highlighted in CONCORD-2 (9-10% lower 5-year survival for blacks) is not replicable in the VA system. This difference is likely due to the uniformity of the VA in providing screening and treatment services and in leveling the playing field in terms of access to care. We believe these results should be taken into consideration in the current discussion of the shape of the healthcare system the US should adopt.

Primary Tumor Sidedness in Colorectal Cancer at VA Hospitals: A Nation-Wide Study

Publish date: September 13, 2018

Author(s): [Azar I.](#), [Esfandiarifard S.](#), [Virk G.](#), [Khreis T.](#), [Mehdi S.](#)

Background: Right-sided colon cancer (RC) is derived from the mid-gut, while left-sided colon cancer (LC) originates from the hindgut. LC has been associated with better survival compared to RC. The effect of primary tumor sidedness on colorectal cancer (CRC) survival rates has not been studied in VA hospitals.

Methods: Data from the National VA Cancer Cube Registry was studied. 65,940 cases of CRC were diagnosed between 2001 and 2015. ICD codes C18 to C20 were used to delineate patients with RC vs. LC. RC was defined as cancer from the cecum to the hepatic flexure, LC from the splenic flexure to the rectum with transverse cancer in between flexures. Local IRB approval was obtained.

Results: Of the total number of CRC, 30.3% were RC and 58.8% were LC. RC constituted 36.3% of cases in women and 30.1% of cases in men. RC was diagnosed after the age of 70 years in 51.8% of cases, compared with 38.5% of LC. LC constituted 56.0% of CRC in blacks, and 59.4% in whites. RC was more likely to be diagnosed at more advanced stage, with 60.84% of cases diagnosed at stage II-IV, compared to

51.82% of LC. Stage IV RC has worse one-year survival as compared with LC (50.5% vs 42.2% surviving less than one year, respectively)

Conclusions: RC is associated with female gender, older age, poorer functional status, and more advanced stage at diagnosis. LC was associated with white race. Stage IV RC had worse one-year survival than LC colon cancer.

Veterans with Colorectal Cancer Have a Higher Incidence of a Second Primary Malignancy Than the Colorectal Cancer Survivors in the General Population

Publish date: September 13, 2018

Author(s): [Jawad A](#), [Backer JV](#), [Ahn NJ](#), [Pastor D](#), [Pasquale D](#), [Le M](#).

Background: Compared to the general population, colorectal cancer (CRC) survivors are at higher risk for developing additional malignancies, with up to 11.5% of male CRC survivors diagnosed with a second distinct malignancy.

Methods: To determine if this trend is similar in CRC survivor veterans, a retrospective analysis of all veterans diagnosed with colorectal cancer (CRC) between 1995 and 2011 within a single Veterans Affairs Medical Center was performed.

Results: Of 1,496 veterans diagnosed with sporadic CRC, 22.6% had developed a second primary malignancy and 2.7% had a third primary malignancy. The most frequently diagnosed second primary malignancies within this cohort included cancer of the prostate (38.5%), lung and bronchus (15.3%), urinary bladder (11.5%), oral cavity and pharynx (6.3%), and kidney and renal pelvis (6.1%). Incidences of second primary malignancies were 24.8%, 27.3%, and 15.9% for veterans of World War II, the Korean War and Vietnam War, respectively.

Conclusions: Our findings indicated that cancer survivor veterans carried even a higher risk of developing a second primary malignancy regardless of their service eras as compared to the general population. Healthcare providers should remain vigilant regarding surveillance for the development of additional, distinct malignancy in this particular patient population.

CONTRIBUTORS

The Cancer Committee would like to extend appreciation to the following contributors to this year's Cancer Program Annual Report. The scope of this information would not have been as extensive without their contributions and support.

Linda Carpinello-Dillenbeck, R.T. (R) (M) (ARRT) Quality Control Mammographer
Bruce Swingle - Chaplain Service
Felicisimo S. Santos, MM, MBA/HCM, RT (R) ARRT - Radiology
Eina Fishman, MD – Past Chief of Staff

The Comprehensive Cancer Committee would like to dedicate this Annual Report to
Cheryl Brennan, Elizabeth Cullen and Margaret DeMars
for their continuous commitment
to the Veterans, Cancer Program and to the staff of the Stratton VAMC.
We “Thank You” for your service!



Cheryl Brennan, RN
Hematology/Oncology



Margaret DeMars, RN and Elizabeth Cullen, RN
Radiation Oncology