



2001 - 2002
Stratton VA Medical Center
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 (ACoS) with areas of responsibilities including: coordinating educational activities for nursing staff, students and professionals; coordinating multi-disciplinary treatment groups such as Oncology and Hematology related clinics and Tumor Board; overseeing the functioning of the Tumor Registry; and coordinating Patient Care Evaluation (PCE) studies. This report represents the following periods: tumor registry report and site reviews are based on the previous calendar year (January 1, 2001 through December 31, 2001); the remainder of the report, including committee membership, statistics and departmental sections are from the period of July 1, 2001 through June 30, 2002.

The Cancer Committee meets to discuss the diagnosis and treatment of patients with malignancy within the facility, as well as reviewing medical records of cancer patients.

Membership

S. Burkart-Jayez, RN	Nurse Executive
G. Chikkappa, MD	Representative Hematology
M. De Mars, RN	Representative Rad/Onc Nurse Coordinator
I. Eglitis, DDS, MS	Representative Dental
E. Fishman, MD	Chief of Staff
M. Heravi, MD	Representative Diagnostic Imaging
L. Hoffman-Hogg, RN, MS, AOCN	Cancer Program Director
J. Holland, MD	Rep. Medical Oncology/ACoS Liaison
R. Ilves, MD	Representative Thoracic Surgery
L. Kelly, RN	Representative Mental Health
D. Keyser, RN	CQI Coordinator
R. Kiehl, MD	Representative Radiation Oncology
D. Kupiak, RPh	Representative Pharmacy
C.Y. Lee, MD	Representative Pathology/Laboratory
M. Martin, RN	Representative Education
N. Memon, MD	Representative Primary Care
S. Osborne, RN	Representative Palliative Care
C. Schwartz, MD	Representative Diagnostic Imaging
S. Silver, MD	Representative Otolaryngology
H. Thayer, CSW	Representative Social Work
L. VanWie, CTR	Tumor Registry
M. Velardi, RN	Oncology/Hematology Nurse Coordinator
H. Wilbur, MD	Representative Urology
B. Williams, LPN	Tumor Registry
T. Wu, MD	Representative General Surgery



Comprehensive Cancer Committee's Report 2001-2002

The Stratton VA Medical Center (VAMC) Cancer Program evaluates and provides treatment for patients from as far north as the Canadian border, as far south as the counties bordering New York City, as far west as midway between Albany and Syracuse (Buffalo for Radiation Therapy), and as far east as mid-Massachusetts and southern Vermont, along with referrals from Kentucky for Intensity Modulated Radiation Therapy (IMRT). We were surveyed by the ACoS in September 2000 and have renewal of full accreditation. The VA and Federal Government recognize the Stratton VAMC Cancer Program as one of their Comprehensive Cancer Centers.

The Cancer Committee continues to hold monthly meetings and has aggressively pursued goals outlined for the 2000/2001 year. These goals are specific and adapted to meet the needs of our program. They are as follows:

- Tumor Board - add educational component pertaining to patient care trends
- TNM Staging
- Pain reporting and management/patient education
- Evaluate and respond to patient medical record documentation
- Evaluate and respond to ACoS request-development of a monitor for compliance of treatment guidelines with chart review at least every 12 months.
- Quality Management (QM) to monitor and organize quality care

These goals are being met.

The program of reviewing patients with diagnosed malignancies at Tumor Board continues to be of major benefit to our patients, as well as an important educational experience for staff. The session was instituted to ensure the highest quality of care for patients, while maintaining that no patients were diagnosed with cancer without medically indicated follow ups and that treatment occurred in a timely manner. During the year, those patients with malignancies reviewed at Tumor Board had treatment decisions formulated by the interdisciplinary group resulting in coordinated appropriate follow up care.

The Stratton VAMC Cancer Program continues to participate in the ACoS's Patient Care Evaluation Studies. We are currently evaluating lung and gastric tumors (for 2001). Increased collaboration between the Tumor Registry and the medical staff demonstrates 100% of the appropriate patients thoroughly American Joint Commission on Cancer (AJCC) TNM staged. We continue to have strong emphasis on educational programs. The Tumor Board continues to be a vibrant multidisciplinary session where critical decisions concerning patient care are made at our institution.

A significant amount of clinical and basic science research continues to be carried out by our institution. Our clinical research involves follow-up for Eastern Cooperative Oncology Group (ECOG), Southwestern Oncology Group (SWOG) and private pharmaceutical clinical trials. These studies include preventative trials, such as lung, and prostate cancers, as well as testing some of the newest and most exciting therapeutic drugs for head and neck, lung, esophageal, gastric, pancreatic, colorectal, bladder, and prostate cancers. Our basic science research concentrates in the areas of molecular genetics and medicinal chemistry. This VA-based research program involves scientists



from multiple institutions, including Albany Medical College, University at Albany, and Rensselaer Polytechnic Institute. The National Institutes of Health, National Science Foundation, and VA Medical Research fund these research activities. Overall, many presentations and publications have emerged out of the research efforts of our group.

The Hoptel Unit is a remarkable housing facility within our hospital. It has a high occupancy rate and provides patients and family members (permitting space availability) to stay over at our hospital during times when they may not require inpatient hospitalization, but either need to stay in the area to undergo the most rapid and streamlined evaluation possible, or as a place to stay during the course of treatments. A significant number of the patients who stay in the hoptel travel from long distances to undergo radiation and/or chemotherapy as this facility has been officially recognized as the Network Center of Excellence for this treatment modality.

The End-of-Life-Care Committee is in place and is headed by Dr. Dan Tobin, the acclaimed author of the book entitled "Peaceful Dying." The goals of the committee are to advise doctors/nurses with the management of painless and peaceful dying of terminally ill patients. Emphasis is focused on providing patients and families with supportive counseling and assistance with concrete, practical issues that arise in the last phases of life, such as legal and financial concerns, as well as with the important psychological issues.

Other important services provided within our programs include: social work support, smoking cessation classes, mammography, dietary support, and a doctor/nurse devoted specifically to clinical pain management.

This is a time of significant change in the health care system of the VA and our country, and our hospital is helping to set the pace for changes. The Cancer Committee has guided the Stratton VAMC Cancer Program through this time of change. We have gone through this process of change through an ongoing commitment of excellence in patient care, education of tomorrow's physicians, and other health care providers, and a strong emphasis on research to develop the treatments of the future. We routinely demonstrate our commitment to high quality of care for our patients by meeting the requirements of the ACoS, the JCAHO, as well as participating in other site reviews such as Office of Research Compliance and Assurance (ORCA). The Comprehensive Cancer Committee continues to set forth and implement specific goals designed to improve the quality of care for our patients. Through a quality assurance program, we continuously reassess our performance and design ways to improve care and outcomes for our patients. Our Tumor Registry collects and stores data on our patients for analyses, with an exceptional followup rate (98%). The Tumor Board is devoted to promoting an interdisciplinary approach to cancer care. The Comprehensive Cancer Committee oversees and encourages clinical and basic science research programs. The committee continues to focus on providing the very best care and aggressively pursues the enhancement of services that we provide to all of our cancer patients.

Sincerely,

Steven M. Silver
Chairman, Comprehensive Cancer Committee



Ongoing and New Initiatives

Cancer Survivor's Celebration: The Tenth Annual Cancer Survivors Celebration was held on Friday June 7, 2002. Approximately 200 cancer survivors and staff members attended this celebration of life. The VA Nutrition/Food Service catered the continental breakfast and barbecue lunch provided. There were patient speakers, as well as an inspiring speech by Dr. Duncan Savage from the Department of Radiation Therapy. There was entertainment provided by our own talented staff member, Calvin Jones, File Room. Other guests included Lisa Vince, pianist and Earl Wallace, country-gospel guitarist. The moderator for this event was our own Lori Hoffman-Hogg, Cancer Program Director. Mary-Ellen Piche, Stratton VAMC Director, spoke to the veterans outlining the hospital goals for cancer care. The American Legion Auxiliary of Rensselaer County did the Advance of Colors. This annual event would not be possible without VetCare donations, as well as others, and the unselfish devotion of our own staff members and the donations received by the committee that were used as raffle items to help off-set the cost of this event. The American Cancer Society (ACS) provided educational materials, as well as free t-shirts for the participants. All had a good time and we are already looking forward to our 11th Annual Celebration to be held on June 6, 2003.

Outreach: We have developed referral links with all Community Based Outpatient Clinics (CBOC). They have access to the Computerized Patient Record System (CPRS) and can look up patient information. In order to assure optimal information flow, computer access to clinical data at these centers has been achieved. When we see a patient from one of our CBOCs we can call up all laboratory, pathology and radiographic data on our system. This has proven to be invaluable in seeing these patients, as well as in handling diagnostic and treatment advice at a distance.

Psychosocial Support: Psychological support is available for patients and families who request help in coping with the diagnosis of a chronic or terminal condition. A psychiatrist or psychologist with expertise in working with cancer patients is available during clinic hours to provide assessment, supportive individual and family counseling and relaxation therapy to patients undergoing chemotherapy and radiation therapy. Appropriate referrals for ongoing psychological support are made when necessary. We are now integrated with primary care and see patients referred by the primary doctor/nurse for any behavior, mental status issues etc., as the doctor/nurse deems necessary. There is a .5 psychologist assigned to the Pain Management Clinic and each Primary Care Clinic, and in the hospital proper, there is (at least) a .5 psychologist assigned to all of the Primary Care Teams. In addition, we offer consultations for patients on the medical-surgical units.

During scheduled clinic hours, a social worker provides support to patients and families and assists with home care needs, transportation, writing of advance directives and other concrete services. In addition, we have a strong networking relationship and patients have multiple options for community-based support groups. We also have our own employees trained to offer the "I CAN COPE" program to our cancer patient population.



Tumor Registry: 2001-2002 has proved to be a challenging, exciting period for the Tumor Registry. We have continued to grow to meet the changing demands of the institution.

As of March 1998, the VA Central Cancer Registry has been up and operating in Washington, DC. The Stratton VAMC has contributed our 1997-2000 data, performed the necessary edits, and successfully participated in this attempt to provide a national cancer data source based on veteran data.

In the spring of 1999, we initiated a process improvement project with the CBOC RNs for abnormal lab results who appear to have a delay in follow-up during Tumor Registry case findings. These cases are summarized and forwarded to the CBOC RNs via e-mail to ensure the appropriate follow up and/or work-up. This has proven to be very useful in decreasing lag time of patient care. New abnormalities are now not only

detected earlier but a formal notification process is now in place for primary care and reported at the weekly Tumor Board Conference.

The Registry participated in the ACoS Patient Care Evaluation on Gastric and Lung Cancer for 2001. Information is gathered concurrently in the course of abstracting, eliminating the need for paper submission. We continue to participate in the National Cancer Database, adding our data in order to better evaluate local vs. national trends in cancer treatment and survival.

Tumor Registrars, Bernice Williams, LPN and Linda VanWie, CTR both attended the National Cancer Registrar's Association (NCRA) Annual Meeting in the spring of 2001 at the Hilton at Disney Hotel in Orlando, Florida. The individual meetings were well represented by national and state members and provided a wealth of information to be shared by our Tumor Registry staff.

2001 Tumor Registry Report

The Tumor Registry at the Stratton VAMC has a reference date of January 1955 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 of staff. Interfacing with all of the components that make up the Cancer Program, the Registry helps promote quality patient care, as well as the needs of the future cancer patients. The registry is currently staffed by Linda VanWie, CTR and Bernice Williams, LPN.

TOTAL CASES	NUMBER	% DEAD	% ALIVE
Since Origin*	19,701	100%	
Total Analytic	15,669		
Total Known Dead	13,832	71%	
Total Under Follow-up	1,837		100%
Total Unknown Status	30		2%
Total Successful Follow-up Rate			98%

*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.



2001 Tumor Board Report

Our weekly Tumor Board is a conference that includes both case presentation(s) and a didactic program. Following each presentation, there is an informal discussion of the case and review of the recommended staging and treatment modalities available. This ensures our patients a multi-disciplinary approach to the treatment of their disease, as well as providing education to the house staff, students, and allied health professionals in attendance.

During 2001, there were 127 presentations (113/89% prospective/11% retrospective) of new primaries, recurrences or follow-ups. Sites presented included: bladder, brain, breast, colorectal, esophagus, kidney, liver, larynx, lung, lymphoma, melanoma, oral cavity, pancreas, pharynx, prostate, soft tissue, stomach, and unknown origin.

The Stratton VAMC has several oncology related specialty clinics that oversee the ongoing multi-disciplinary care and treatment for various patients. The Ear, Nose, and Throat (ENT) Clinic is held three times a week, seeing 35-40 cancer patients weekly. The General Urology (GU) Clinic sees an average of 35-40 patients with cancer each week. The Medical Oncology Clinic sees approximately 40 patients weekly, and Hematology sees about 35 (both malignant and pre-malignant) cancer patients weekly depending on the chemotherapy schedules. Radiation Therapy averages 19 veteran treatments per day. Approximately 7-10 cancer patients attend Thoracic Surgery Clinic weekly.



Primary Site Table - 2001

PRIMARY SITE	# %		CLASS OF CASE		ANALYTIC AJCC STAGE						
			A	NA	0	I	II	III	IV	U	N/A
ALL SITES COMBINED	609	100.0	546	63	61	195	94	54	61	29	52
HEAD & NECK (except Larynx)	26	4.3	23	3	1	9	3	3	7	0	0
DIGESTIVE SYSTEM											
Esophagus	10	1.6	10	0	0	0	6	2	2	0	0
Stomach	11	1.8	9	2	1	2	0	3	2	1	0
Colon	13	2.1	13	0	0	4	1	3	4	1	0
Rectum/Anus	16	2.6	16	0	0	5	6	2	1	2	0
Liver/Biliary	4	.7	4	0	0	0	0	1	1	2	0
Pancreas	4	.7	4	0	0	0	0	0	4	0	0
Gallbladder	1	.2	1	0	0	0	0	0	0	1	0
RESPIRATORY SYSTEM											
Access Sinuses	1	.2	0	1	0	0	0	0	0	0	
Larynx	16	2.6	13	3	2	4	1	2	4	0	0
Lung	87	14.3	74	13	0	11	5	28	27	3	0
SKIN	210	34.5	204	6	41	145	6	2	0	7	3
CONNECTIVE TISSUE	2	.3	2	0	0	0	0	1	0	1	0
BREAST	3	.5	3	0	1	1	1	0	0	0	0
VAGINA	1.2	0	1	0	0	0	0	0	0	0	
UTERUS	1	.2	1	0	0	0	1	0	0	0	0
GENITOURINARY ORGANS											
Prostate	85	14.0	69	16	0	0	57	0	3	8	1
Kidney/Renal Pelvis	4	.7	4	0	0	2	0	1	1	0	0
Bladder	33	5.4	28	5	2	5	4	3	1	3	0
Ureter	1	.2	1	0	1	0	0	0	0	0	0
Penis	1	.2	1	0	1	0	0	0	0	0	0
Testis	1	.2	1	0	0	1	0	0	0	0	0
Other Urinary	1	.2		0	1	0	0	0	0	0	0
EYE	1	.2	1	0	0	0	0	0	0	0	1
BRAIN/PERIPH NERVES	10	1.6	8	2	0	1	0	0	0	0	7
THYROID/OTHER ENDO	5	.8	1	4	0	0	0	0	0	0	1
LYMPH NODES	13	2.1	12	1	0	4	2	2	3	0	1
BLOOD & BONE MARROW	40	6.6	34	6	0	1	1	1	1	0	30
UNKNOWN PRIMARY	8	1.3	8	0	0	0	0	0	0	0	8

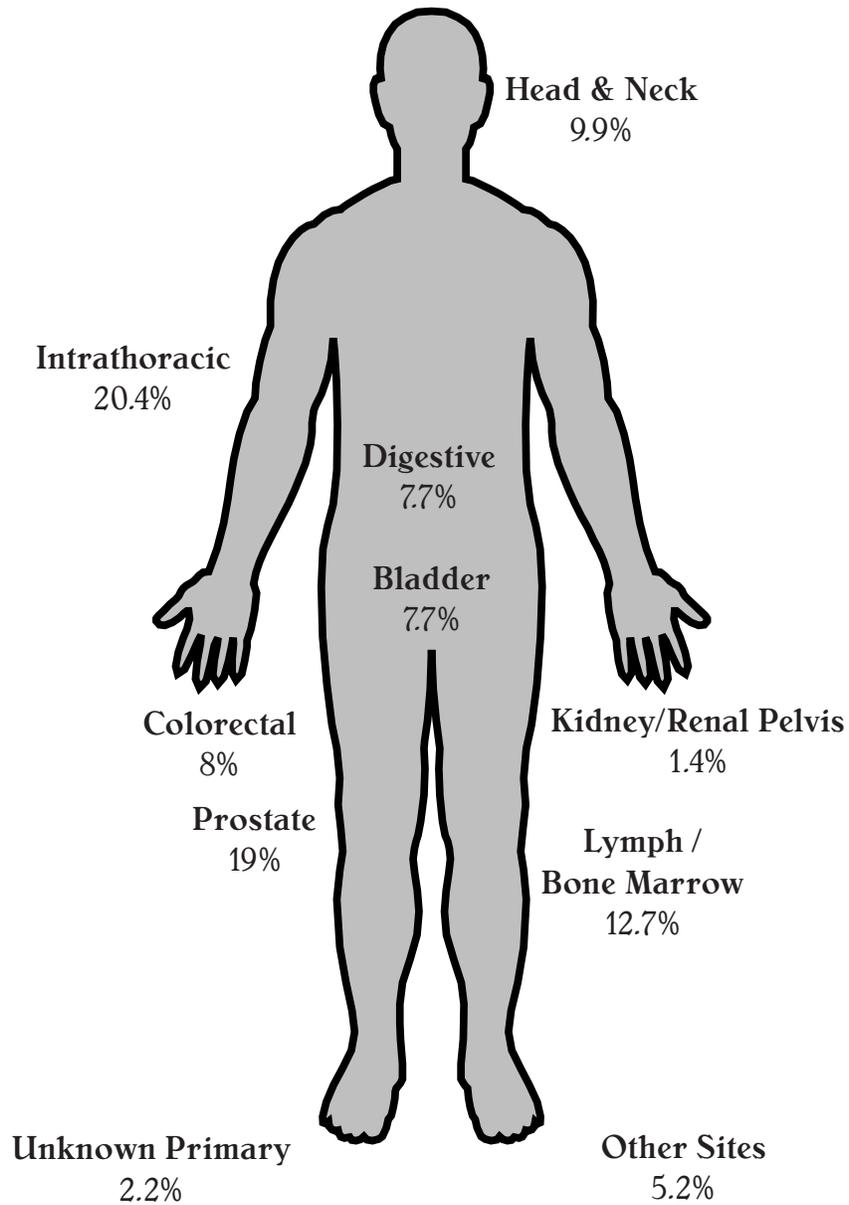
A=Analytic NA=Non-Analytic U=Unknown N/A=Not Applicable

*Doesn't include 183 localized Basal and Squamous Skin Cancers.



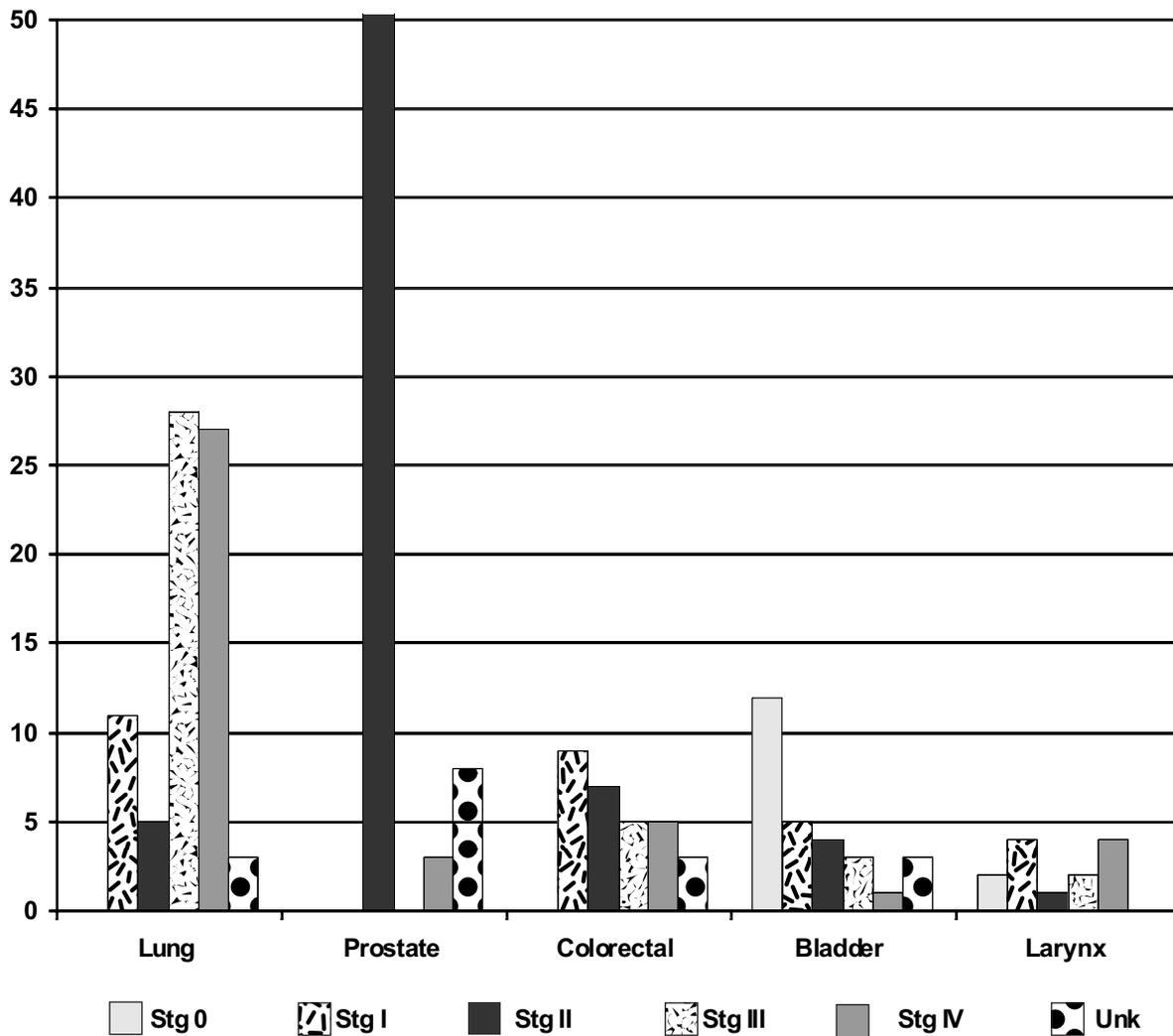
Cancer Incidence By Primary Site

2001 Analytic Cases - 363*



*Doesn't include 183 localized Basal and Squamous Skin Cancers.

Five Most Frequently Occurring Primary Sites - 2001 Distribution by AJCC Stage Analytical Cases



Cancer Prevention and Early Detection

Dental Service Cancer Program

The Stratton VAMC 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 conditions for tumor therapy management
- (3) To maintain effective recall for follow-up care of these patients

On admission to the hospital, all suspected head and neck cancer patients are to be referred by consultation to the Dental Service. Dental referrals are to be made for patients referred to Radiation Therapy for irradiation of the head and neck. Each patient is assessed on an individual basis in regard to overall systemic health, tumor 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 will provide appropriate integration of medical/dental care, reduce management complications, and best serve the health and welfare of the patients involved.

All patients are instructed in proper oral hygiene. Radiation patients are placed on a fluoride therapy protocol and are seen on a weekly basis during radiation therapy to screen for any untoward oral sequelae such as mucositis, xerostomia, loss of taste, and radiation caries. Patients who experience any oral sequelae to radiation therapy are appointed for follow up on a long-term basis. In light of this stringent follow up program, only about three cases of osteoradionecrosis have been reported at this center in a 20-year period and NO cases in the past reporting year.

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 prostheses such as tongue bulbs or extra-oral facial prostheses.

A survey was conducted of the head and neck cancer patients identified during the calendar year 2001 based on data obtained from the Stratton VAMC 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.



Dental Service saw 28 of 33 patients. Three laryngeal carcinoma patients not seen had surgical resection: one had a carcinoma in-situ, laser surgery with no postoperative ERT. Another spends the winter in West Palm Beach and summers in the Adirondacks. He received External Radiation Therapy (ERT) in Florida but had the total laryngectomy here. The third patient underwent a supraglottic laryngectomy and ERT here, but passed away within a year. Two patients referred for chemotherapy treatment have not been examined: one patient with a hypopharyngeal lesion and another with a base of tongue lesion. Oncology clinic was notified.

The rate of examination of head and neck cancer patients is lower than we would like. With the introduction of computerization in health care, we no longer manually check lists such as ward admission diagnoses and operating room schedules. Instead, we have to rely on consultations generated by the Head and Neck Protocol. The referring services send these patients to Dental Service for supportive care, as needed.

The reduced staffing problems of the Dental Service contribute to the challenge of seeing every identified head and neck cancer patient. An interdisciplinary continuous quality improvement team has developed a Head and Neck Clinical Protocol to insure timely notification and consultation with respective services. However, this protocol is set to notify us on presentation of a T2 or greater lesion, but not with a T1 lesion. We also depend upon ENT to set the clinical protocol in motion.

In short our examination rate of head and neck cancer patients has been as follows:

Calendar Year	1992	67/67	100%
	1993	37/38	97%
	1994	48/51	94%
	1995	33/37	89%
	1996	44/48	92%
	1997	34/37	92%
	1998	19/26	73%
	1999	29/35	83%
	2000	29/34	85%
	2001	28/33	85%

The data was integrated into the table developed last year for an overview of patients identified and screened during 1983-2001. The data reflects the interdisciplinary approach of management of head and neck cancer patients very well. Tables have also been developed to illustrate the numbers of patients diagnosed by site at the Stratton VAMC and numbers of these patients screened and/or treated by Dental Service during 1983-2001. The Stratton VAMC Dental Service plays an integral role in the treatment of such patients.



Head and Neck Cancer Patients 1983-2000

Tumor Site	Number of Patient Identified	Number of Patients seen by Dental Svc.	Patients seen by Dental Svc.
Tongue	130	117	90.
Salivary Glands	13	9	69.2
Gingiva	12	12	100.
Floor of Mouth	81	77	95.1
Other Mouth	74	67	90.5
Oropharynx	101	96	95.
Nasopharynx	25	23	92.
Hypopharynx	97	90	92.8
Nasal Cavity	25	23	92.
Larynx	311	279	89.7
TOTAL	869	793	91.25%

Head and Neck Cancer Patients Screened and/or Treated By Dental Service 1983-2000

	1983-87	1988-92	1993-97	1998-99	2000-01
Tongue	39	31	30	10	7
Salivary Glands	0	9	0	0	0
Gingiva	1	5	2	0	4
F.O.M.	24	22	20	7	4
Other Mouth	27	18	14	1	7
Oropharynx	21	38	28	5	4
Nasopharynx	6	11	4	1	1
Hypopharynx	35	25	26	2	4
Nasal Cavity Sinuses	6	13	2	2	0
Larynx	77	86	70	20	26
TOTAL	236	258	196	48	59

**Head and Neck Cancer Patients
1983-2001
Incidence By Site**

	1983-87	1988-92	1993-97	1998-99	2000-01
Tongue	41	35	33	12	9
Salivary Glands	0	13	0	0	0
Gingiva	1	5	2	0	4
FOM	25	22	22	7	5
Other Mouth	27	21	15	3	8
Oropharynx	23	39	29	6	4
Nasopharynx	6	11	4	3	1
Hypopharynx	36	25	27	3	6
Nasal Cavity Sinuses	6	15	2	2	0
Larynx	89	90	77	25	30
TOTAL	254	276	211	61	67



Women's Health

As stated in Network Memorandum 10N2-116-00, NETWORK 2 HEALTH CARE FOR WOMEN VETERANS, dated November 27, 2000, policy for the Women Veterans Program is: to integrate high quality physical and behavioral care, preventive and rehabilitative services, and to address the promotion of quality improvement, health promotion and disease prevention, customer service, education and research, and accountability at all Network 2 facilities including CBOCs. The overall health care services goal is: to provide the spectrum of services outlined in VHA Handbook 1330.1, SERVICES FOR WOMEN VETERANS, dated May 2, 2001. Standards of care are consistent with VHA Directives, ACS, and the Agency for Health Care Policy and Research (AHCPR) Clinical Practice Guidelines. The veteran is encouraged to be a full partner and active participant in her health care. Network 2 External Peer Review Practice (EPRP) scores are highest for all Networks in the area of mammograms (92%) and paps (97%) and Albany is proud to present numbers documenting success rates at Stratton VAMC. Dr. Caroline Schwartz joined the Stratton VAMC family as Chief of Radiology, May 2002. Dr. Schwartz is well known within the community as a Mammography Radiologist.

From July 1, 2001 to June 30, 2002, a cytotechnologist at Stratton VAMC examined 506 pap smears. Of the total specimens, 417 (82.4%) were within normal limits; 55 (10.9%) were reported as reactive cellular change; 11 were atypical glandular cells of uncertain significance (AGCUS); 1 positive for malignant cells; 4 squamous intraepithelial lesion, high grade; 2 squamous intraepithelial lesions, low grade; 12 atypical squamous cells of uncertain significance (ASCUS); 4 or 0.8% were unsatisfactory specimens). All abnormal or suspicious reports were appropriately followed to resolution (24 endometrial bx; 15 endocervical/cervical bx; 1 vaginal bx; 4 vulvar bx; 9 partial

hyster/ovary/tubes/hysterectomy). Dr. Sabrina Hussain, continues as provider for gynecology services. She was appointed June 2001 to fill the vacancy created by Dr. E. J. Degnan's resignation as provider for gynecology services. The GYN Clinic also has a Family Nurse Practitioner and an Advanced Practice GYN Nurse who have collaborative agreements with Dr. Hussain to evaluate routine, non-complex cases. Women have the choice of receiving an annual exam at the hospital-based GYN Clinic or through primary care and any of the CBOCs. The number of consults to the GYN Clinic has steadily increased thus documenting an increase in the number of women being reached for preventive health screening. (Historical growth: 1994 = 253; 1995 = 268; 1996 = 249; 1997 = 321; 1998 = 339; 1999 = 359; 2000 = 437; 2001 = 473).

In March of 1998, the standard for breast health screening developed by Network 2 Women Veterans Health Care Council was adopted. This comprehensive standard addresses clinical breast exams, mammography, and client education for breast self-exam. In fiscal year 2000, Stratton VAMC mammography reached a new record with 700 mammograms performed. This year that record has again been broken with a new total of 915 mammograms. In September 1998, Kathy Prividera, RN, MS, CS, GNP, Women Veterans Program Manager was invited to present the Breast Health Partnership Model at the Federal Coordinating Committee on Breast Cancer Conference in Washington, DC. The Partnership with Albany County Department of Health and the ACS is now in its seventh year. As Stratton VAMC continues to increase the number of partnership clients, we have specifically become the mammography site of choice for all Whitney Young Clinic doctor/nurses. Stratton VAMC had the proud distinction of being the only VA nationally to participate in this type of community



activity. Under Stratton VAMC's guidance, the VA Western New York Healthcare System at Buffalo has formed a partnership with Erie County. Kathy Prividera presented during the concurrent sessions of Partnerships for Health in the New Millennium: Launching Healthy People 2010, January 2000, Washington, DC as part of the cancer focus for prevention and early detection programs. Last year, Kathy Prividera completed the ACS's training as an "I CAN COPE" facilitator.

"I CAN COPE" is an educational course provided in a supportive environment for adults with cancer and their family members and friends. It is designed to help participants with selected aspects of their cancer experience by increasing their knowledge, positive attitudes, and skills. Stratton VAMC is scheduled to host a community session.

January 2002, Dr. Eckart Schackow joined the VA staff to fill the vacancy of Dr. Gail Capel. In February 1999, Dr. Gail Capel received her certification as a Mammography Radiologist. Stratton VAMC Women's Imaging Center Mammography received full reaccreditation through June 3, 2005. Stratton VAMC hosted several community agencies for a Mammography Quality Standards Act (MQSA) Food and Drug Administration (FDA) Satellite Conference. On June 2002, Stratton Imaging Center for Mammography passed its third annual FDA National Mammography Standards Inspection for MQSA. As we celebrate the eighth anniversary of the opening of the mammography suite, it is with pride that we announce a fourth perfect MQSA inspection and a perfect score on a random Clinical Image Inspection. Linda Carpinello-Dillenbeck, RT, Mammographer, was invited to Northport VA as a consultant, to assist in identifying opportunities for enhancing mammography services at that facility. That facility passed the next inspection; unfortunately cost factors have recently closed that in-house unit. Linda has been honored with selection to

serve on the Albany Chapter of the ACS (ACS) Board of Advisors. In collaboration with the ACS, Linda has assisted with forming a special outreach group for Hispanic women in the Capital District and Johnstown area. A VA cancer survivor continues to work with the "Tell-a-Friend" Program. Kathy Prividera hosted the ACS spring training session at Stratton VAMC for professionals seeking clinical breast examination certification.

Between July 1, 2001 and June 30, 2002, 915 patients received mammography services at the Stratton VAMC. Eight were referred for biopsy with outcomes as follows: one apocrine cyst; one multi focal DCIS (CRIBIFORM, micro papillary and solid patterns; one with two fibroadenoma and fibrocystic changes plus foci of ductal hyperplasia; one fibrocystic changes and sclerosing adenosis and foci of micro calcifications; one fibroadenoma; one per surgeon - pending for one year follow up; one referral pending bx and one Infiltrating Ductal Carcinoma (on baseline)- treatment was mastectomy, chemo, and tamoxifen. Fourteen patients continue on six month follow-up regimens.

Two hundred fifty-nine, family members, friends, volunteers, veterans and employees made-up the team to join the community in the Making Strides Against Breast Cancer Walk, October 2001. As a Flagship Sponsor, the VA team raised more than \$10,040 for breast cancer care and research in the local community. Strides 2001 VA team, Stratton VAMC's sixth year, had additional pride as a woman who was diagnosed and received all her surgery and treatments at the Stratton VAMC and was selected by the ACS as the guest speaker for the event's kick-off. Her story and praise for the treatment she received was featured in the "Times Union" as the 2001 Cancer Survivor. Stratton VAMC will be a Corporate/Flagship sponsor for the 2002 Strides Walk.



The women veterans software package released nationally in 1999 continues to be refined. This package provides more accurate data collection, outcome measures, more timely appointment reminders and follow up of care, in addition to letters for results notification. Stratton VAMC has exceeded expectations as a role model in implementation of this package.

Stratton VAMC mammography re-screen rate is 96%, far surpassing the private sector best practice rate. Kathy Priverera had worked with Hines CIO, Chicago on the development of an anatomical breast form to be included on the electronic order entry for mammograms to ensure clinical breast exam findings are well defined. She is also a member of the National Technical Advisory Group (TAG) for the interfacing of the Women Veteran's Health Package (WVHP) software and CPRS for a more efficient electronic record. Mammograms are now included for electronic ordering.

In April 2000, Kathy Priverera was appointed to the National Data Capture Task Group for Military Sexual Trauma (MST); contributed to the white paper: MST Software Implementation: Best Practice and Guidelines and Models; and remains a stakeholder in refining the functionality of the software. While MST is gender-neutral, it impacts greatly on the gender specific health issues of women who have experienced such trauma.



Cancer Care and Support Services

Chaplain Service

Chaplains interact with oncology inpatients and outpatients in both formal and informal settings. Patient contacts occur in casual supportive conversation, spiritual care visits, sacramental ministrations, and in worship services. The chaplain's goal is to foster the patient's spirit of hope and confidence that enhances the benefits of medical care, as well as enabling the patient to cope with the inevitable fragility and uncertainty of life.

CONTINUITY OF CARE - Chaplain Service has the unique opportunity of providing spiritual care and emotional support to oncology patients regardless of their movement among various wards and clinics, or the frequency of admissions. In the course of daily visits to all Critical Care Unit patients, as well as regular visits with all new admissions, pre- and post-surgical patients, medical/surgical wards, a meaningful spiritual counselor and caregiver relationship often develops. This tends to increase the significance of the more traditional ministries of sacrament and prayer with patients. For many patients and their families, these contacts lead to drop-in office visits while they are here for medical appointments.

This continuum of care in many cases begins even before the initial cancer diagnosis and continues through the various stages of treatment, to life and death decision-making, and bereavement support for a family already well known to the chaplain.

Additionally, effective in September 2002 the Chaplain Program has re-established its Radiation Unit Spiritual Support Program by placing a chaplain in the waiting room for an hour and a half at least one morning each week. This affords the opportunity of providing spiritual support to patient and next of kin at a stressful juncture in their lives, as well as enhancing the supportive efforts of Radiation Unit personnel.

END-OF-LIFE (EOL) PLANNING - Chaplains track patients of EOL-related diagnoses, including cancer, more diligently than more routine cases. In addition to referral information from the Advanced Illness Coordinated Care Program we find it most helpful when the attending physicians or nurses alert us to a focused and immediate need in regard to a poor prognosis subsequent to biopsy or surgery. This permits timely spiritual/emotional support for both family and patient.

PALLIATIVE CARE PROGRAM - Chaplains participate in the interdisciplinary care plan of the Palliative Care Unit (PCU) by means of interdisciplinary patient review meetings, and providing regular spiritual care visits upon all PCU patients. There is frequent opportunity to render spiritual care support to families, often including bedside prayers of commendation to God upon the patient's death. A chaplain always participates in periodic memorial services conducted by PCU staff.

BEREAVEMENT SERVICES - Memorial masses are regularly provided upon request. In addition, a letter of sympathy over the director's signature is sent to all next of kin of deceased veterans enrolled in Stratton VAMC announcing semi-annual memorial masses for Catholic veterans, as well as semi-annual non-denominational "Roll Call and Remembrance" memorial programs for all other veterans.

CANCER SURVIVORS CELEBRATION - Chaplain Service is pleased to provide participation at the planning committee level, as requested. Chaplain Service provides a supportive role at the formal ceremony portion of the program, as well as interacting with outpatients gathered for annual this event.



Enterostomal Therapy

The scope of practice of the Enterostomal Therapist includes functioning as a professional nurse for patients with fecal or urinary diversions, wounds, drains, pressure ulcers and incontinence. This includes acute care, rehabilitation and patient/caretaker teaching and counseling. Educational opportunities are provided to staff and patients.

The therapist initiates and provides ongoing evaluation of patient care management of all patients with stomas and those anticipating ostomy surgery. The therapist also provides care to patients with head and neck cancer who have G-tubes placed for feeding.

Hematology/Medical Oncology Report

The Hematology/Medical Oncology staff is comprised of three full-time physicians, one part-time physician, one full-time Physician Assistant, three full-time RNs, one part-time RN and one full-time LPN. We also have three Research Study Coordinators. The utilization of part-time nursing staff allows for flexibility of adjusting schedules to meet the needs of our patient population. The nurses are available on a rotating schedule to meet the treatment needs of patients on the weekend. Hematology/Oncology nurses serve as a resource for other nursing staff in the inpatient, outpatient and community arenas.

The Infusion Suite is open Monday through Friday and on an as needed basis on weekends. It is located adjacent to the clinic area where patients are seen by physicians. The suite is a nurse-managed area with physicians available, as needed. There is capacity to care for seven patients at any given time (five treatment chairs and two beds).

The responsibilities of the Hematology/Oncology Nurses include:

- Teaching patients and their caregivers about the disease process and treatment plan
- Enabling patients to cope with symptoms of their disease and side effects of their therapy
- Safe administration of cytotoxic therapies
- Administration of blood and blood products

More opportunities and treatment options, including research protocols, were made available to our cancer patient population over the past two years. When appropriate, patients and their significant others are taught the procedures for administration of injections, biological response modifiers, and growth factors. This enables them to care for themselves at home, therefore, leading a more normal life.

From July 1, 2001 to June 30, 2002, there were a total of 5,643 encounters. This shows an increase of 1,143 visits or 25.4%.

Palliative Care Program

Since its inception in April 1986, the Palliative Care Program has provided inpatient hospice services to terminally ill veterans and their families, along with consultation services to patients not able to be cared for on the Hospice Unit. Clinical work with patients and families experiencing the burdens of terminal illness includes:

Providing holistic, comfort care with an emphasis on promoting independence and quality of life; strengthening family support; managing pain and other symptoms; and assisting the patient in achieving death with dignity.

Developing and implementing an interdisciplinary care plan that can meet the physical, emotional, social, and spiritual needs of the people under our care.

Encouraging patients and families to participate in deciding what is right for them.

Making available a variety of bereavement services to support family members after the death of a loved one.

Ongoing analysis of the program has demonstrated that the needs of terminally ill patients and their families can be met on an inpatient Hospice Unit by an interdisciplinary staff with a primary emphasis on treating the patient and family as one unit of care.

Hospice home care services are available to all veterans on a referral basis through certified community hospice agencies. The patient's care is directed by the VA primary care doctor/nurse. The community hospice agency will work with the patient's health insurance carrier or assist in obtaining needed coverage. The Home Based Primary Care (HBPC) program offers comprehensive primary care in the home and coordinates the community hospice care for homebound patients. HBPC provides 24/7 primary care coverage.

Patients who do not meet the community eligibility standards for hospice care can still receive palliative care through HBPC. In these cases, an interdisciplinary team is available to address the bio-psychosocial needs of the patient. If, and when, the patient can no longer be cared for in the home, they have a choice of being admitted to the Stratton VAMC inpatient hospice unit or the community hospice inpatient unit at a local hospital.

Social Work Services

The primary focus of the Oncology/Hematology 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 in our institution have been served by social work. Patients and families are offered psychosocial support as they receive diagnosis and treatment. They are also assisted in obtaining appropriate in-home and community services to enhance their quality of life.

Our residential housing program for veterans who are receiving cancer treatment and live a distance from the medical center has continued to flourish. Lodging and board is provided at no cost to patients and their caregivers at the hoptel. A hoptel is designated wing of the hospital that provides a homelike environment for independent patients and caregivers that live a distance from the hospital. The hoptel has been designed with the radiation therapy patient as a primary focus of its mission. In addition, the Oncology Social Worker continues to be involved with a unique housing program called Fisher House. The Fisher House is a large Tudor-style house built on the grounds of the hospital, which provides a homelike environment for patient's families while their loved one is hospitalized.

Participation on the Advanced Illness/Fair Care team continues. Emphasis is focused on providing patients and families with supportive counseling and assistance with concrete, practical issues that arise in the last phases of life, such as legal and financial concerns. This team responds to formal referrals of patients and families who are facing an advanced illness and would benefit from increased support and assistance. Many of the patients referred to this program have been recently diagnosed and/or are living with cancer. This program provides patients with support, guidance and end of life planning, if necessary.



The Oncology Social Worker helps patients face the challenges of end-of-life planning. Advanced directives are discussed with new Oncology and Radiation Therapy patients. Paperwork is provided and completed when patient and family is 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. Linkage with Certified Home Care Hospice programs appeared to be especially helpful.

Speech Pathology

Speech pathology provides comprehensive evaluation, treatment, education and counseling to the cancer patient population with deficits in swallowing, communication (language, speech, voice) and /or cognition. Services are provided throughout the continuum of care, frequently beginning in the preoperative phases, when appropriate, and continuing postoperatively until maximum function is obtained.

This year, cancer related referrals were 22% of the total Speech Pathology caseload. Twenty-four percent of these patients were seen for communication disorders, 34% for swallowing disorders and the remaining 42% for both communication and swallowing problems. Seventy-five percent of the cancer related referrals were head and neck sites with 46% of these being the larynx as the primary site.

The head and neck cancer patients have been tracked via the "Head and Neck Clinical Protocol." Speech Pathology is formally consulted on all surgically treated head and neck cancer patients. Previously, patients receiving radiation therapy were not routinely referred to Speech Pathology despite having the potential for swallowing and/or communication

problems. This year, in cooperation with Radiation Oncology, all patients with a diagnosis of head and neck cancer are being referred to Speech Pathology for formal evaluation, monitoring, and active intervention during and after radiation.

LARYNX: Sixteen total laryngectomees were formally seen by Speech Pathology. There were seven new total laryngectomy patients. Four received primary Tracheoesophageal Punctures (TEP) at the time of surgery. Five secondary TEPs (separate surgical procedure after total laryngectomy) were also done. Sixty-five percent of the TEP patients have functional speech. The others are using the electrolarynx as their primary means of verbal expression. Some reasons for failure of the TEP include recurrence, healing complications, and lack of patient participation in training/therapy. Cooperation between Otolaryngology and Speech Pathology continues to occur. Interdisciplinary problem solving has been invaluable to maximize benefits to the TEP patients. This type of procedure is problem prone and time consuming for staff. The benefits to the patients are significant, greatly improving quality of life.

Other options for communication include use of the electrolarynx. Sixty percent are functional users. Twenty-five percent are marginal users but can be successful with an attentive, familiar, communication partner. Eighty-two percent of the total laryngectomy group has functional swallowing.

Seven patients, with laryngeal cancer, treated with radiation and/or chemotherapy, were followed during treatment. All were able to adequately nourish themselves, via oral means alone, with the use of liquid nutritional supplements. Three of the patients experienced moderate to severe dysphonia and were able to benefit from the use of a voice amplifier. Vocal quality improved after radiation therapy was completed.



OTHER HEAD AND NECK SITES: These sites include: epiglottis, lip, tongue, retromolar trigone region, floor of mouth, alveolar ridge, pharynx, base of tongue, and tonsillar area. Fifty percent of these patients are able to take nutrition and hydration via oral means alone. The remaining patients rely on gastrostomy tube feedings or a combination of oral and G-tube feedings. Eighty percent of the patients have functional speech/voice. The others utilize an amplifier to increase volume.

OTHER SITES: Other sites were esophagus, lung, brain, bladder, as well as multiple myeloma and non-Hodgkin's lymphoma. Compromised medical status and a deconditioned physical state negatively impact upon swallowing function for all patients.





Diagnostic Procedures and Treatment for Cancer Patients

Nuclear Medicine

1. Between July 1, 2001 through June 30, 2002, a total of 248 cancer patients visited Nuclear Medicine Service with a total of one I-131 therapy for thyroid cancer and 247 diagnostic procedures performed (please refer to Table 1 and Table 2 for details).
2. Cancer patients and researchers can benefit a great deal from the amazing advances in instrumentation and pharmaceuticals in the field of Nuclear Medicine. At this medical center with present equipment, we are able to perform most of these procedures.

Diagnostic Procedures

Table 1

<u>TESTS</u>	<u>PATIENTS</u>
Bone densitometry	1
Bone Scan	197
Ejection fraction	43
Gallium	2
I-131 total body scan for thyroid cancer	1
Liver/Spleen	2
Parathyroid	1
Ventilation and perfusion	1

Therapeutic Procedures

Table 2

Quadramet therapy	0
Strontium 89 therapy	0

TOTAL = 248



Oncology Clinical Research

The Oncology Research Department has continued to provide non-traditional treatment options for our veterans. During the past year, approximately 70 patients were enrolled and participated in research studies for gastric, head and neck, prostate, colorectal, pancreas, and non-small cell lung cancers. In addition to these treatment options, the Oncology Research Department has initiated participation in two cancer preventions trials for prostate cancer and bladder cancer. The SELECT trial is a large multicenter, international prostate cancer prevention trial sponsored by the National Cancer Institute that will eventually enroll approximately 32,000 men over the next five years. The following is a list of research studies that were available to the veterans during the past year:

VA Cooperative Group Studies

<u>Protocol #</u>	<u>Title</u>
404	Prostate Cancer Intervention Versus Observation Trial (PIVOT): A Randomized Trial Comparing Radical Prostatectomy Versus Palliative Expectant Management for the Treatment of Clinically Localized Prostate Cancer
410	Iron (Fe) and Atherosclerosis Study (FeAST)
499	S0000: Selenium and Vitamin E Cancer Prevention Trial (SELECT)

Pharmaceutical Studies

<u>Protocol #</u>	<u>Title</u>
RP56976-V TAX 326	A Multi-Center, Multinational Randomized Phase III Study of Docetaxel (Taxotere) Plus Cisplatin Vs. Docetaxel Plus Carboplatin Versus Vinorelbine plus Cisplatin in Chemotherapy-Native Patients with Unresectable Locally Advanced and/or Recurrent Stage IIIB or Metastatic (Stage IV) Non-Small Cell Lung Cancer
BAM-CLN-01	A Randomized, Open-Label, Stratified, Parallel-Design, Controlled Study of BAM-002 for the Treatment of Patients with Stage IIIB or Stage IV Non-Small-Cell Lung Cancer in Conjunction with Chemotherapy
RP56976-TAX 322	A Randomized, Phase II/III Multicenter Trial of Docetaxel (Taxotere(r)) Plus Cisplatin and Docetaxel Plus 5-FU Versus Cisplatin Plus 5-FU in the First Line Treatment of Patients with Recurrent and/or Metastatic Squamous Cell Carcinoma of the Head and Neck



RP56976-TAX 324	A Randomized, Phase III, Multicenter Trail of Neoadjuvant Docetaxel (Taxotere) Plus Cisplatin and 5-Fluorouracil (TPF) Versus Neoadjuvant Cisplatin Plus 5-Fluorouracil Followed by Concomitant Chemo-radiology to Improve the Overall Survival and Progression Free Survival in Patients with Locally Advanced Squamous Cell Carcinoma of the Head and Neck
RP56976-TAX 325	An Open-Label, Randomized, Multicenter, Multi-Phase II/III Study of Docetaxel in Combination with Cisplatin (CDDP) or Docetaxel in Combination with 5-FU and CDDP (Cisplatin) Compared to the Combination of CDDP and 5-FU in Patients with Metastatic or Locally Recurrent Gastric Cancer Previously Untreated with Chemotherapy for Advanced Disease
GC4	Open, Label, Multi-National, Multi-Center Study of G17DT Immunogen in Combination with Cisplatin and 5-Fluorouracil (5-FU) in Subjects with Metastatic or Locally Recurrent Gastric or Gastroesophageal Cancer Previously Untreated with Chemotherapy
RP56976-V-TAX 327	A Multicenter Phase III Randomized Trial Comparing Docetaxel Administered Either Weekly or Every Three Weeks, in Combination with Prednisone Vs Mitoxantrone in Combination with Prednisone for Metastatic Hormone Refractory Hormone Prostate Cancer
PC4	Prospective, Randomized, Controlled, Double-Blind, Multi-Center Study of G17DT Immunogen in Combination with Gemcitabine Versus G17DT Placebo in Combination with Gemcitabine in Previously Untreated Subjects with Locally, Advanced (Non-Resectable Stage II and III), Recurrent Disease Following Primary Resection, or Metastatic (Stage IV) Adenocarcinoma of the Pancreas
SR96669 EFC 4584	A Multicenter, Open-Label, Randomized Study of 5-Fluorouracil 5-FU) and Leucovorin (LV) or Oxaliplatin or a Combination of 5-FU-LV + Oxaliplatin as Second-Line Treatment of Metastatic Colorectal Carcinoma
SR96669 EFC 4585	A Multicenter, Open-Label, Randomized, Two-Arm Study of rinotecan (CPT-11) Vs the Combination of Oxaliplatin + Irinotecan (CPT-11) as Second-Line Treatment of Metastatic Colorectal Carcinoma (MCRC)
SR96669 EFC 4759	A Multicenter, Open-Label, One-Arm, Phase II Study of Single Agent Oxaliplatin as Third-Line Treatment of Metastatic Colorectal Carcinoma
SR96669 LTS7072B	A Treatment Access Program with Oxaliplatin for Previously Treated Colorectal Cancer Patients



AVF2107g	A Phase III, Multicenter, Randomized, Active-Controlled Clinical Trial to Evaluate the Efficacy and Safety of rhuMab VEGF (BEVACIZUMAB), in Combination with Standard Chemotherapy in Subjects with Metastatic Colorectal Cancer
AVF2192g	A Phase II, Multicenter, Double-Blind, Randomized, Active-Controlled Clinical Trial to Evaluate the Efficacy and Safety of rhuMab VEGF, A Recombinant Humanized Monoclonal Antibody to Vascular Endothelial Growth Factor, In Combination with 5-Fluorouracil and Leucovorin Chemotherapy in Subjects with Metastatic Colorectal Cancer who are not Optimal Candidates for First-Line CPT-11
CC6	A Multicenter, Open-Label, Single-Arm, Phase II Trial of G17DT Immunogen in Combination with Irinotecan in Metastatic Colorectal Carcinoma Refractory to Previous Irinotecan-based Chemotherapy
DFMO341	Phase III Randomized, Double-Blind Study of DFMO vs. Placebo in Low Grade Superficial Bladder Cancer
NQ4-99-02-006	Phase IIb/III Chemoprevention Trial of Celecoxib to Prevent Recurrence of Superficial Bladder Cancer
N91-00-02-079	Clinical Protocol for a Randomized, Double-Blind, Placebo-Controlled Parallel Group Comparison of the Analgesic Activity of Valdecoxib (SS65872) 20 mg BID Versus Diclofenac 75 mg BID in Patients with Chronic Cancer Pain, IND 52,153

VAMC - Albany

Protocol #
RDIS 0019

Title
Genetic Variants of Phospholipase A2 and Atherosclerosis

Information regarding clinical trials is available by calling:

Stratton VAMC

Elissa Ball, RN, CCRP
(518) 626-6447

Lori Megherian, CCRP
(518) 626-6448

American Cancer Society
1-800-4-CANCER



Performance Management

“Our mission is to care for our veterans with compassion and excellence. Our vision is to be the health care provider of choice, achieving the highest quality in health care delivery, education, and research. We are committed to adding value to our mission by modeling our core values: trust, respect, commitment, compassion, and excellence.”

Quality and appropriateness of care rendered to oncology patients are reviewed using the following criteria:

- Occurrence Screening
- Management of Care
- Utilization Review Criteria
- Patient Safety/Risk Management
- Performance Measures

Each case, meeting at least one of the criteria, was subjected to clinical review, root cause analysis (RCA), and/or peer review as appropriate. RCA identifies basic reasons that cause or contribute to an adverse event or close call. The analysis focuses primarily on process design and organizational changes. Completed review requires lessons learned, action plans, completion dates, and outcome measurement strategies.

The Tissue and Procedure Committee conducts annual tissue and procedure appropriateness reviews. Oncology related issues include bone marrow, bronchoscopy, colonoscopy, colon resection, endoscopic biopsy, or resection of bladder lesions, laryngectomy, and open thoracotomy with lung resection, radical neck dissection, and Transurethral Resection of the Prostate (TURP). The committee also does surgical case reviews in which positive margins are reviewed for follow up.

Hospital-wide monitors, which include oncology patients within the scope of review, autopsy review, blood usage evaluation, drug usage evaluation,

infection control, medical record review, morbidity and mortality review, patient incident review, and pharmacy and therapeutics review inclusive of adverse drug reactions. In all primary care clinics, patients aged 50-69 years, who are eligible, receive education on the risks and benefits of prostate screening. During July 2001 - June 2002 86% of those patients who met criteria, received education.

All care/service lines involved in the treatment of oncology patients have systematic processes in place to measure the quality and appropriateness of care. The VA is involved in a nationwide EPRP. This process provides a national VA database for comparison to national standards in primary prevention and early detection of breast, cervix, and colon cancer. Patient encounters are selected for review monthly by VAMC software. The hospital-wide monitoring through EPRP review includes Primary Care Clinics in-house and some community-based outpatient clinics. The reviewed timeframe covers July 2001 through June 2002. The results are as follows:

Colorectal Screening- 320 charts reviewed, patients age 50 and older who did not refuse colorectal screening/ 221 charts, a of total 69%.

Cervical Cancer Screening- 23 charts reviewed- female patients age 50 through 69 who were not excluded due to previous hysterectomy and who did not refuse screening. Those screened for cervical cancer by Pap test, charts reviewed 20, a total of 87%.



Breast Cancer Screening - 14 charts reviewed, female patients age 50-60 who were not excluded due to previous bilateral mastectomy and who did not refuse screening. Patients received a mammogram for breast screening, 13 charts reviewed, a total of 93%.

Network 2 has determined that based on successful Clinical Practice Guidelines (CPG) EPRP scores during 2nd and 3rd quarter fiscal year 2002, cervical cancer screening and breast cancer screening will no longer be monitored as a primary diagnosis. Both breast and cervical cancer screenings will continue to be monitored annually by Women's Health.

In addition, end-of-life planning and palliative care for cancer patients are reviewed.

Process improvement plans are in place for those preventive indicators below 78%.

The Tumor Registry tracks the timeliness of treatment plans after an initial diagnosis of cancer using guidelines established by the ACoS Commission on Cancer. All adverse events and close calls are forwarded to Patient Safety and Risk Management for review.

Pharmacy Service

Pharmacy Service continues to be an integral part of the oncology care team. Pharmacy practitioners within the clinical pharmacy section serve as an authoritative information source on antineoplastic drugs, including proper dispensing techniques, preparation, and their utilization in therapies. The clinical pharmacy specialists evaluate the current professional literature for analysis of experimental design and conclusions, in order to compare and contrast therapeutic regimens and uses for antineoplastic therapy as well as those therapies required to palliate neoplastic disease related syndromes/symptoms. In addition, the clinical pharmacy specialists design antineoplastic dosage regimens utilizing pharmacokinetic and chronotherapeutic principals and specific patient parameters when requested by the attending physicians. The clinical pharmacists design, conduct, and participate in studies, audits, and evaluations concerning the utilization review of antineoplastic drugs, under the auspices of the Therapeutic Agents and Pharmacy Review Committee, Quality Assurance, and Research and Development Committee.

Members of our clinical pharmacy department continue to be active in research and have been recognized for several publications and national presentations. Currently, the Oncology Pharmacy staff consists of a full-time Clinical Oncology Pharmacist and a full-time Oncology Pharmacy Technician. In addition, there is a Research Pharmacist who devotes approximately 50% of his time to clinical cancer research trials.



Radiation Oncology

The Network 2 Center of Excellence for Radiation Oncology is located at the Stratton VAMC. Radiation Oncology referrals are received from within Network 2, as well from many other VA medical centers in the northeast region including the VAs at Castle Point, NY; White River Junction, VT; Northampton, MA; and Wilkes-Barre, PA. Referrals for radiosurgery have come from as far away as Lexington, KY. One hundred eighty-one patients have been treated over the past year and a total of 4,493 treatments were delivered.

The center has state-of-the-art treatment and planning equipment and houses the only Stereotactic Radiosurgery and Intensity Modulated Radiation Therapy (IMRT) programs in the VA system in the entire Northeast. The Radiosurgery/IMRT program opened in April of 2000 and a multitude of disease entities have been treated since that time. The center has had a high rate of success with patients that are re-treated for lung cancer, using IMRT. The average life expectancy is 15 months. Patients treated were those with lung cancer that recurred after conventional radiation treatment.

Regionally renowned board certified and/or board eligible Radiation Oncologists provide expert treatment that is delivered with the highest of standards that match or exceed the standards of cancer care in the community. Beginning in the fall of 2001, brachytherapy (seed implants) have been offered as a treatment option for prostate cancer patients and performed at one of the two community hospitals if the patient is deemed a candidate. The Stratton VAMC is in the process of developing a seed implant program and we are looking forward to the initiation of this endeavor within the coming year.

The Radiation Oncology department is a teaching site for the Radiation Therapy Technology program based at Upstate Medical Center in Syracuse, New York. Students rotate through the department and have experiences in therapy, dosimetry, and nursing. The department is also a teaching site for dental and pharmacy residents, as well as students of nursing, dietary, and rehabilitation medicine.

The highest levels of quality care are assured via a detailed Continuous Quality Improvement (CQI) process. All new patient's charts and treatment plans are reviewed by a non-treating physician. This assures appropriateness of plans and often initiates discussions that are pertinent to specific patients and disease sites. All other charts are checked weekly for completeness. The multi-disciplinary CQI team meets on a monthly basis and reports on the monitors that are specific to their section. Medical CQI focuses on issues related to unexpected deaths, reasons for delays in treatments, and unexpected outcomes. The patient's treatment plan is reviewed in the event of a potentially Radiation Therapy (RT) related incident or occurrence. CQI in nursing focuses on RT side effects, implementation of Advanced Directives and monitoring of consult notes for content that is felt to be pertinent. This information includes such items as complete staging, documentation of an exact plan of care, and inclusion of Karnofsky performance status and pain scale.

Simulations (treatment planning) for definitive cases are done in conjunction with a CT scan. This 3-D planning not only offers the most current information in relation to the patient's tumor, but also allows for precise planning that minimizes effects on normal structures while optimizing the radiation effect on the desired area. Outcome from a CQI monitor that was performed does well to document the advantages of using the CT to guide the placement of RT fields. For this reason, 3-D planning has become the standard of care.



In addition to the simulator machine, the department has two linear accelerators for treatment. Both are Varian machines. One is a Clinac 6 and the other is a Clinac 2100. The Clinac 2100 is the dual energy (photons and electron capability) machine that is modified for the linac based Stereotactic Radiosurgery.

There are two registered nurses that work full-time in the Radiation Oncology department. They share the workload for the treatment patients and perform case management for each radiation patient. They are each responsible for the coordination of care of their patients including: travel, housing, management of RT side effects, and coordination of support services. Both of the nurses are members of the Advanced Illness Care Team and follow patients in this regard, as well. The patients are offered housing for treatment at either the Fisher House or the hospital. Other support services that are coordinated through the RT department include nutrition, speech and swallowing therapy, pain management, physical therapy, social work service, and home care services. The nurses also coordinate the follow up of the patients and communicate the plan with the referring service.

The clinical staff is active on the Tumor Board, the Comprehensive Cancer Committee, hospital-wide Pain Oversight Committee, and the Brachytherapy Planning Committee. Radiation Oncology Nursing is well represented in the community as Faculty for the North Eastern New York (NENY) Oncology Consortium. This consortium was designed to standardize oncology nursing education in our region. Our faculty Nurse Representative for NENY Oncology Consortium maintains her OCN certification and our Cancer Program Director is Advanced Oncology Certified Nurse (AOCN). The Radiation Oncology staff is active in clinical research and has published on the topics of Radiosurgery and on the topic of the use of feeding tubes during head and neck radiation.

Radiology

Angiography - In the past 16 months since the opening of our Philips Intergrity Angio Suite, business has been booming to say the least. We have seen a large increase in line placements and other intervention type procedures in particular. The addition of our recently received Sono Site portable ultrasound unit has made gaining vascular access much easier without the bulk of the older machines. Word of our image quality and technical expertise has traveled throughout the hospital and we are also asked to provide imaging assistance with pain management cases, as well as gastrointestinal and pulmonary cases. Our caseload has nearly doubled over the past years and we continue to provide high quality patient care and imaging for the more demanding and interesting cases we do each day!

MRI - As of April 1, 2002, the new Philips Intera 1.5 Tesla MRI Suite is successfully up and running. We have already experienced a 25% increase in the number of cases performed during our training and initiation period. The addition of our Medrad Spectris MR Injector has allowed us to perform high quality renal artery, dynamic liver, and venogram studies. These studies were never before performed at this facility. There is a dramatic increase in the quality of our studies due to the increased field strength of this new magnet. Patients are quite pleased with the decreased scan times and new bright pleasant environment in the scanning room. The addition of the audio sound system has been the biggest hit! It provides a choice of listening music while drowning out the noise of the machine while it is scanning. We look forward to continuing to provide high quality exams at a faster pace as we continue to increase our capabilities.



Cat Scan continues to be the workhorse of the Radiology Department. We work closely with the Radiation Therapy and Oncology Departments to provide vital studies in the treatment and detection of cancer. There has been nothing but praise from all the parties involved. There is a minimal waiting period for scheduled studies and acute patients remain a priority. Our experienced staff continues to shine in everyone's eyes!

Vista Imaging is up and running within the hospital. Cat Scan and MRI studies can be viewed immediately following their completion. Our radiologists can view CAT scan call cases from home and provide instant readings.

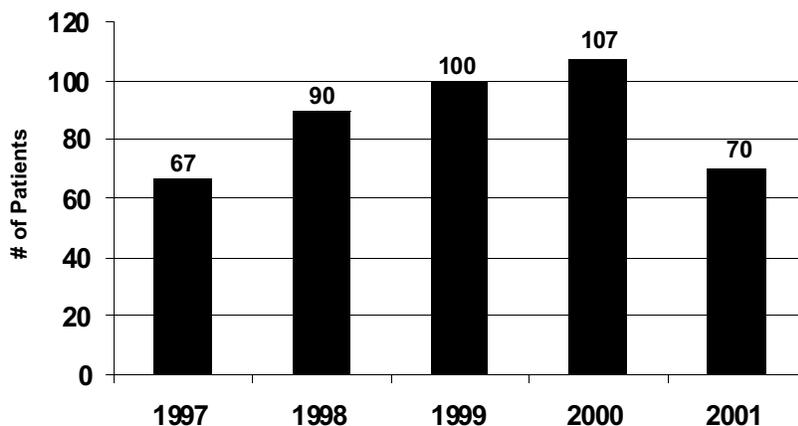
Mammography - These accomplishments and a review can be located under Women's Health.

Lung Cancer

In the United States, there were about 17,000 new cases of lung cancer in 2001, being 13% of all new cancers. The incidence in men peaked in 1984 and has since declined. In women, the incidence peaked in 1997 and has begun to level off. Mortality in men has also declined, while in women it is continuing to increase, though at a slower rate than earlier.

YEARLY CASELOAD ACCRUALS 1997 - 2001 LUNG CANCER

Figure 1
(N-434)

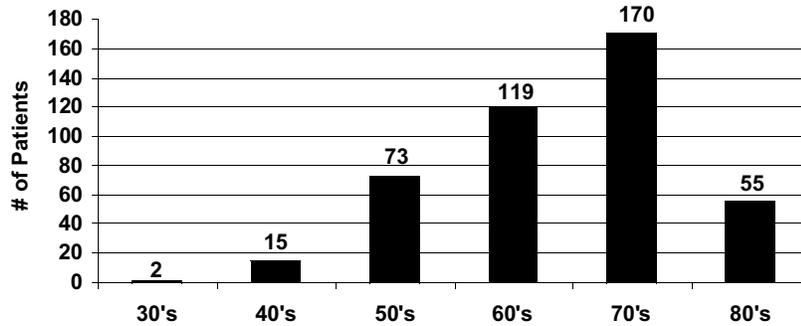


The case accrual rate of our VA has remained fairly steady when compared back to 1984 with a substantial drop in 2001. It remains to be seen whether that drop is the beginning of the same trend as nationally or not.



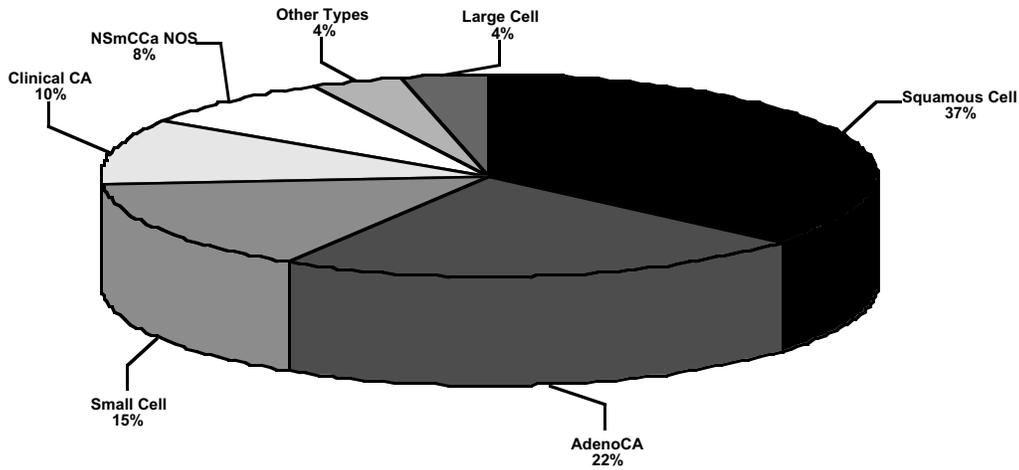
AGE AT DIAGNOSIS 1997 - 2001 LUNG CANCER

Figure 2
(N-434)



HISTOLOGIC DISTRIBUTION 1997 - 2001 LUNG CANCER

Figure 3
(N-434)

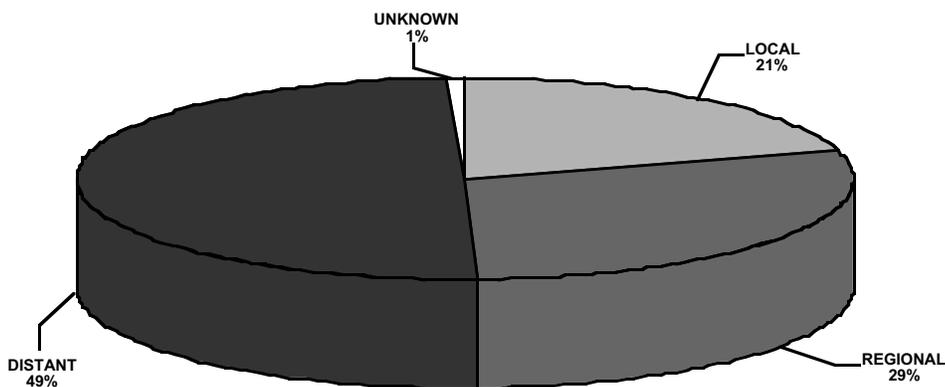


The histologic distribution is fairly similar to the national figures. The slightly higher percentage of squamous and small cell carcinoma probably reflects the higher smoking population at the VA.



SEER STAGE DISTRIBUTION 1997 - 2001 LUNG CANCER

Figure 4
(N-434)



AJCC STAGE DISTRIBUTION 1997 - 2001 LUNG CANCER

Table 1
(N-434)

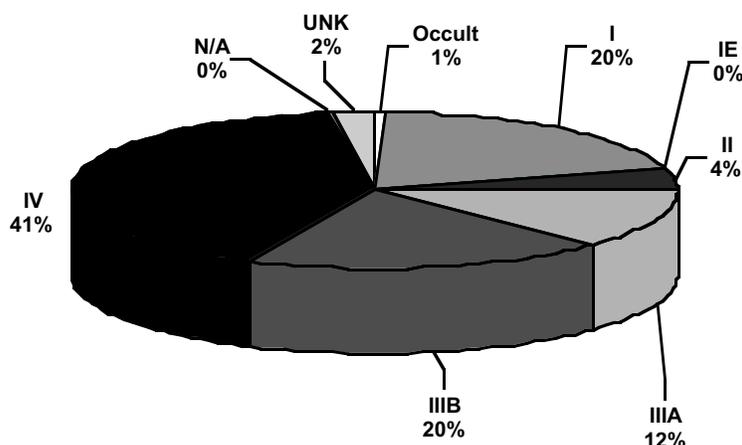
STAGE	#	%
Occult	3	0.7
I	85	19.6
IE	1	0.2
II	19	4.4
IIIA	53	12.2
IIIB	85	19.6
IV	177	40.7
N/A	1	0.2
UNK	10	2.3

The reason lung cancer carries such a high mortality is that it is often diagnosed at a late stage. Sixty percent of our patients present in Stage IIIB or Stage IV, thus being inoperable and much less likely curable. Early stage cancers, most amenable to surgical cure, totaled less than 25%.



AJCC STAGE DISTRIBUTION 1997 - 2001 LUNG CANCER

Figure 5
(N-434)



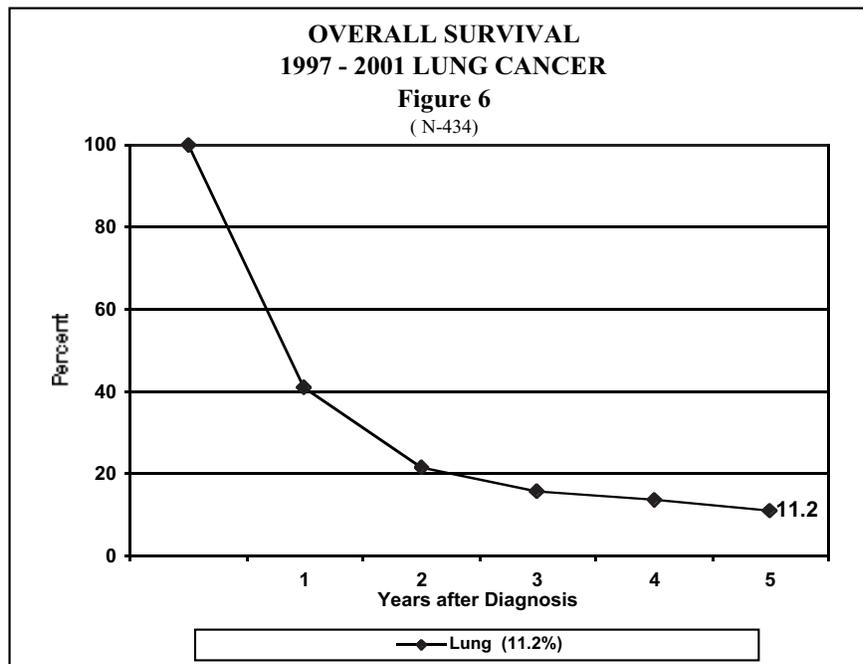
This graphic illustrates stage at presentation in our population.

INITIAL TREATMENT BY AJCC STAGE 1997 - 2002 LUNG CANCER Table 2 (N-434)									
TREATMENT	Occult	I	II	III	IV	UNK	N/A	Total	(%)
None	1	30	4	36	58	7	0	136	(31.3%)
RT Only	1	6	3	17	44	0	0	1	(16.4%)
Surgery Only	0	46	10	7	1	0	1*	65	(15.0%)
Surg/Chemo	0	0	0	4	3	0	0	7	(1.6%)
Surg/RT	1	0	1	3	5	0	0	10	(2.3%)
Surg/Chemo/RT	0	1	1	9	3	0	0	14	(3.2%)
Chemo Only	0	0	0	20	35	1	0	56	(12.9%)
Chemo/RT	0	3	0	41	28	2	0	74	(17.0%)
Chemo/RT/HRM	0	0	0	1	0	0	0	1	(0.2%)

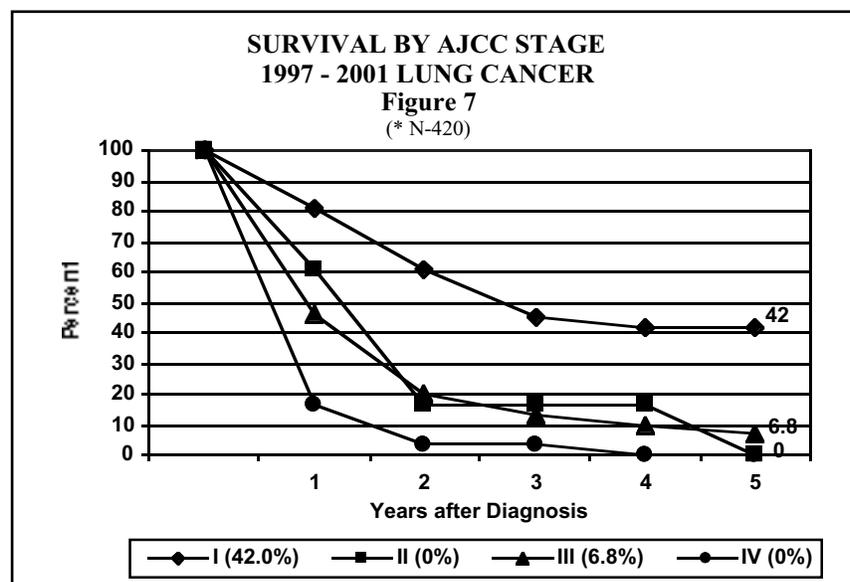
* 1 malignant carcinoid - AJCC N/A based on histology.

Lung cancer is treated by chemotherapy, radiation therapy, surgery or a combination of these. This depends on the patient's stage and performance status. It is disheartening to note that almost one-third of our patients received no treatment, suggesting very late stage when only palliative care was appropriate. Only 20% of patients had surgery, or surgery plus other treatment. This small group constitutes our positive curative cases.





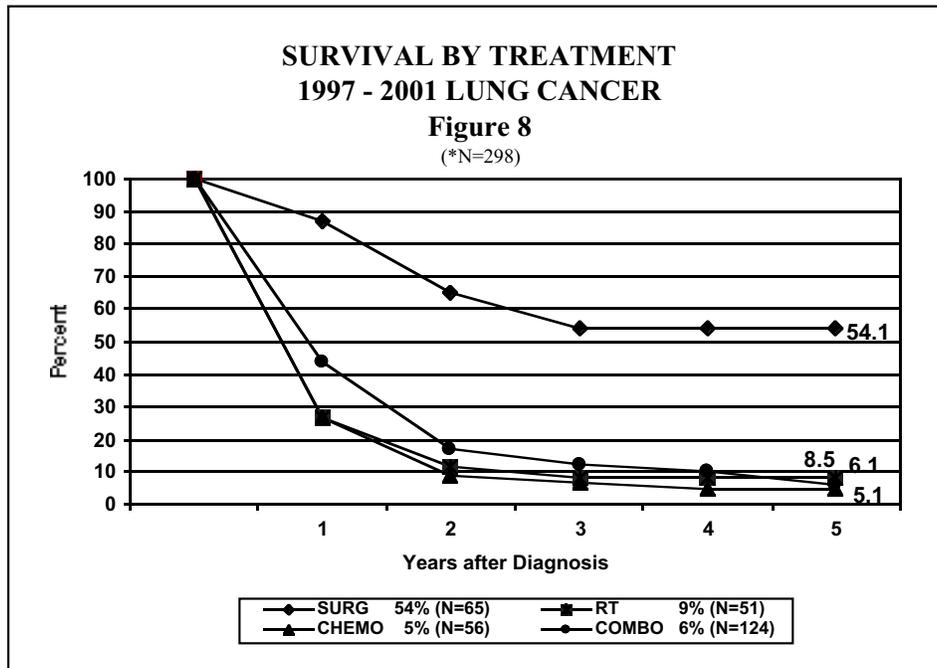
This somewhat dismal survival curve reflects the aggressiveness of lung cancer and the late stage that it is often found.



* Fourteen cases (3 occult, 10 Unknown and 1 N/A) dropped.

Breaking the patients down by stage, the survival curves for early stage disease show good long term survival, and late stage disease essentially has no long term survival.





* One hundred thirty-eight cases dropped (136 No Treatment and 2 CNS RT only)

As stated previously, if surgery can be employed, indicating earlier stage disease, survival is good. All other treatments give very low long term survival rates.

**OPERATIVE MORTALITY
PERCENTAGE BY PROCEDURE
1997 - 2001 LUNG CANCER**

Table 3
(N-122)

Procedure	Total	Deaths	% Deaths
Exploratory	45	4	8.8%
Pt Resection/< 1 Lobe	14	0	0.0%
Lobectomy/Bilobectomy	51	0	0.0%
Pneumonectomy	8	0	0.0%
Rad/Ext Pneumonectomy	2	0	0.0%
Surgery on Reg/Dist Sites	2	0	0.0%
Totals	122	4	3.2%

* 79 cases of No Procedure & 233 cases of biopsy only excluded.

It is commendable that there was no operative mortality in resected cases in this five-year period. That is despite the fact that many of our patients are older and have other co-morbid conditions.



**COMPARISON OF
FIVE YEAR SURVIVAL RATE OF LUNG CANCER
Table 4**

	STRATTON VAMC LUNG	NATIONAL
STAGE	1997 - 2001 n=420*	Lung n> 5319
I	86 / 20%	1876 / 35%
II	19 / 5%	386 / 7%
III	138 / 30%	1541 / 29%
IV	177 / 42%	1427 / 27%

* Fourteen cases (3 occult, 10 Unknown and 1 N/A) dropped.

Revisions in the International System for Staging Lung Cancer, Clifton F. Mountain, MD, Chest 1997; 111:1710-17, Chest/111/6/June 1997.

In comparison to national data, patients at the VA present at a later stage of disease. Nationally, 35% present in Stage I, compared to our 20%. The national Stage IV's are 27% to our 42%. Since survival depends on stage, our overall survival is worse.

In summary, the incidence of lung cancer at the VA appears to be stable. Too many of them, however, are presenting at a late stage. While our surgical care is excellent, most patients are not candidates for this curative modality. In the long term, smoking avoidance and early cessation together with better methods for early diagnosis should cut the incidence and high mortality of this disease.



Contributors

The Cancer Committee would like to extend its 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.

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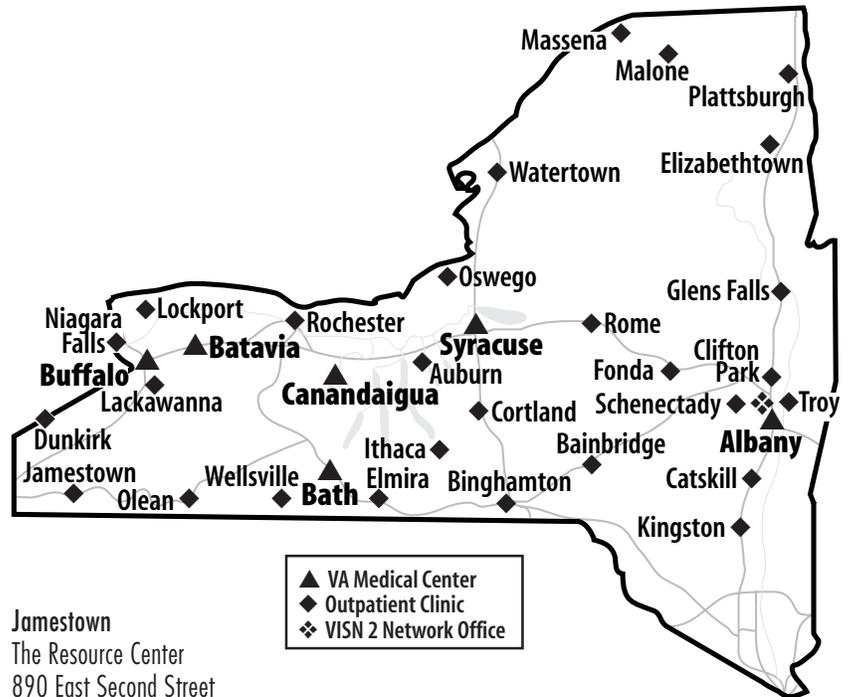
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