



VA Connecticut
Healthcare System
Cancer Program
Annual Report
2014

(Utilizing 2013 Registry Data)

2014 Cancer Program Annual Report
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VA CONNECTICUT HEALTHCARE SYSTEM MISSION STATEMENT

Honor America's Veterans by providing exceptional health care that improves their health and well-being.

**VA CONNECTICUT HEALTHCARE SYSTEM CANCER PROGRAM
MISSION STATEMENT**

Promote the health of our Veterans by providing state-of-the-art cancer prevention, screening, and treatment programs; by educating the next generation of cancer care providers; and by expanding knowledge through research.

**VA Connecticut Healthcare System
2014
Cancer Committee**

The Cancer Committee at the VA Connecticut Healthcare System is a multidisciplinary forum dedicated to providing state-of-the-art, comprehensive patient care. The focus of the committee is to ensure that our Medical Center provides excellent cancer prevention and screening programs, and that quality care is provided to all cancer patients. To achieve these goals, the Committee actively promotes and complies with the standards of the American College of Surgeon's Commission on Cancer.

Cancer Committee Members

Coordinators

Director Cancer Center, Chairperson
Cancer Liaison
Quality Improvement
Quality Control of Registry Data
Cancer Conference
Certified Tumor Registrar

Michal Rose MD
Anthony Kim MD
Herta Chao MD PhD
Jia Li MD PhD
Michal Rose MD
Donna Connery CTR
Tammy Smith CTR

Members

Radiation Oncology
Pulmonary Medicine
Chief, Pathology
Geriatrics/Long Term Care
Cancer Program Administrator
Chief of Surgery
Chief, Diagnostic Radiology
Urology
Pain Control
Social Worker/Case Manager
Pastoral Care
Research/Data Manager
ACS Control Representative
Nutrition
Performance Improvement/Quality Mgmt.
Patient/Family Education
Oncology Nurse
Cancer Care Coordinator

Bryan Chang MD
Hilary Cain MD
Robert Homer MD, PhD
Linda Accordino APRN
Paul Mulinski PhD
Ronnie Rosenthal MD
Caroline Taylor MD
Charles Walker MD
Tracy Shamas RN
Donna Doris LSW
Rev. Sergei Bouteneff
Monica Delvy

Jennifer Jay RD
Tammy Golden RN
Jacquelyn Wolf RN
Marcia Burkitt RN
Julie Beck APRN

Chairperson's Report

This has been an exciting year at the Cancer Center. We had our College of Surgeons on-site visit on June 6. The surveyor was very complementary to our program, and we were awarded **7 of 7** possible **commendations** and the “**Gold**” award. We continue to offer veterans state-of-the-art treatments for their cancer. Eleven new therapeutic agents were approved for the treatment of cancer in 2014, many of which are already in use in our clinic. Furthermore, Veterans who do not have effective, standard of care treatments are offered participation in clinical trials, either at our VA or at other institutions. The VISN1 Oncology clinical trials network, of which we are active members, has enabled us to hire another research coordinator and to open more clinical trials on site. An exciting part of this initiative is an emerging precision oncology program, which is on schedule to “go live” in 2015 and will offer tumor sequencing to help select more targeted and less toxic therapy for patients. We also continue to promote healthy living for our cancer survivors who receive personalized treatment summaries and recommendations for health maintenance and cancer prevention and screening.

We very much enjoy our new space which some may argue is not so new anymore (we moved in August 2012). However, we still appreciate it, especially since most of us worked in the old area. The larger space allows us to offer true multidisciplinary care. Our patients meet routinely with an oncology pharmacist and a nurse prior to starting chemotherapy. They have available to them our palliative care team, a social worker, a dietician, a health psychologist, all in close proximity. We continue to conduct patient and caregiver support group meetings in our Survivorship Center. This year, for the first time, we held a Thanksgiving lunch for Veterans and families in the Survivorship Center on the Monday before the holiday. It was truly heartwarming to see our patients enjoy a good meal and each other’s company, and we have all decided that this will be another Cancer Center annual tradition.

As this report demonstrates, the Cancer Center at VACT Healthcare System brings together providers from all disciplines to prevent and treat cancer. We are also very grateful to our administration for their continued support and to the many other entities that work with us to care for our Veterans such as the Volunteer Services of VACT and the American Cancer Society. I continue to feel privileged to belong to such a dedicated group of individuals.

*Michal Rose, MD
Director, Cancer Center*

Cancer Liaison Report

I have been the Cancer Liaison for the VACT Healthcare System for the past 5 years and have continually been impressed at the level of cancer awareness, education and screening that has been promoted by the VA Connecticut Cancer Center. The role of the Cancer Liaison is primarily to promote the quality of care delivered at our institution, to serve as a liaison between the Commission on Cancer, sponsored by the American College of Surgeons and our local Cancer Program, and to facilitate community outreach programs. As such, we have a highly successful Cancer Survivor Day that has been both a celebration of our VA cancer survivors as well as an educational platform to continue to reach out to the community. Our group is planning to host another Cancer Survivor’s day in the upcoming year.

This past year the VACT Healthcare System we continued our Oncology Education Series, a continuing medical education event centered on increasing awareness and knowledge regarding specific cancers and their care teams. This year on May 2, 2014, by our diverse and expert staff presented the many and diverse diagnostic and therapeutic advances associated with head and neck

malignancies. The day-long multidisciplinary educational conference was well attended by a variety of clinicians including physicians, nurse practitioners, physician's assistants, nurses and other healthcare providers. This again highlighted the outstanding services offered within the VACT Healthcare system for a variety of other cancers.

Our center has a close partnership with our local American Cancer Society chapter, and continues to work in coordination with the ACS to provide resources to our patients. The majority of our cancers are reviewed at our Tumor Board Conference, and due to the large volume of cases, we have separate Multidisciplinary, Pulmonary Nodule, Urologic, Hematologic, Liver and GI Tumor Boards as well. The role of the Cancer Liaison is continually evolving, but the mission remains the same: to continue to strengthen and develop our VA Connecticut Cancer Center.

*Anthony Kim, MD, FACS
ACoS Liaison*

Cancer Registry Report

Data of patients who are diagnosed and/or treated for cancer at the VA Connecticut Healthcare System are abstracted into the Cancer Registry. VA Connecticut Healthcare System's registry is a computerized data collection and analysis center. The registry operation is directed by the Cancer Committee, in accordance with the American College of Surgeons Commission on Cancer standards for a Veterans Affairs Cancer Program.

The data is reported in accordance with the standards set forth by the Veterans Affairs Central Cancer Registry in Washington D.C., the Department of Public Health for the State of Connecticut and the National Cancer Database. Since the reference date of 2000, 7929 cases have been included in the database, 6706 being analytic. Approximately 636 cases are entered annually. There were 595 cases (analytic cases) added during 2013.

Ten percent of all analytic cases are reviewed by VA Connecticut Healthcare's Quality Control Physician for quality assurance. Edit checks of cases are periodically returned on data submitted to the Veterans Affairs Central Cancer Registry, the State Cancer Registry and the National Cancer Database of the American College of Surgeons. Discrepancies are reviewed, corrected and resubmitted by the Cancer Registrar.

Every patient entered into the database is followed on an annual basis to assure correct and complete data. The cancer registry's lifetime follow-up rate of 97% exceeds the Commission on Cancer's standard of 90%. The registry's rate for follow-up of living patients of 99% exceeds the standard of 80%. The registry's follow-up rate for all patients diagnosed within the last 5 years is 98%, exceeding the standard of 90%.

Bladder Cancer was the site chosen by the Cancer Committee for a long term survival study and is included in this report.

*Donna Connery CTR, CPC-H
Tammy Smith CTR
Cancer Registry*

Cancer Care Coordinator Report

During FY2014, we continued and expanded several initiatives to increase early detection and diagnosis of non-small cell lung cancers in our veterans, many of whom are at high risk for lung cancer. We continue to track the daily alerts that are generated by our automated Cancer Care Tracking System ("CCTS") which tracks radiology codes on chest imaging to identify patients with

suspicious lung nodules. Patients identified as having lung nodules deemed suspicious due to size or location are discussed in our weekly multidisciplinary Pulmonary Nodule Tumor Board and individualized plans for follow up are determined for each patient. These plans are then entered into CCTS triggering automated reminders for follow-up, thereby increasing patient compliance.

During 2014, the caseload of early cancers and nodule finding continues to be approximately double historical rates and there has been a continuous shift to diagnosis of non-small lung cancers at earlier stage (50% of new lung cancers diagnosed as Stage I and 10% diagnosed at Stage 2). This is due to the widespread use of low-dose screening CT for lung cancer in patients who meet the high risk criteria (ages 55-74, current smoker or quit within the last 15 years with 30 pack-years), and with the ongoing close monitoring of lung nodules with imaging following national guidelines and Pulmonary Nodule Tumor Board review of nodules >8 mm in size. Screening CT for lung cancer became widespread June 1st 2013. Since that time, the volume of alerts generated by CCTS and the Pulmonary Nodule Tumor Board caseload has more than doubled. In order to maintain our timeliness from suspicion→diagnosis→ treatment, the pulmonary, oncology and cardiothoracic surgery APRN-coordinators communicate daily. We have also seen an increase in the number of Cancer Care Coordinator consults ordered by primary care providers to assist them in arranging for imaging, tissue diagnosis and arranging travel and other services. Cancer Coordinator consults average 5 per month.

During 2014, we also grew our multidisciplinary Cancer Survivorship Clinic. The clinic serves patients who are survivors of early stage lung, colorectal or melanoma cancers. Patients are seen in clinic every 3 to 6 months and are followed for five years. We work closely with Health Psychology, Social Work, Physical Therapy, and Nutrition to insure that Patients have services in place to help them make life-style changes to help them stay healthy. Particular attention is paid to assisting patients with smoking cessation, adopting a healthy diet, maintaining a regular exercise routine and managing stress. This clinic is open to patients three days a week. Over the course of the next year, it is expected that over 80 patients will be seen in this clinic.

During 2013, we developed a template that is now used to create an individualized Cancer Survivor Treatment Summary and Care Plan for each patient seen in our Cancer Survivorship Clinic. Over the course of the year, 75 Treatment Summaries were created and provided to patients and additional treatment summaries are created as new patients are seen in clinic. The completed Treatment Summaries become a permanent document in the electronic medical record and are provided in hard copy form to patients. This template has been well received by our patients and their families and provides an accurate, easy to locate, complete summary of the patient's diagnosis and treatment for primary care providers and other caregivers within the VA System. It can also be a portable record for patients to take with them if they change providers or move to a different VA. Ten other VA's across the U.S. have requested permission to use our template and we expect to roll the template out for use in other oncology clinics at West Haven. I presented our template and our work in creating a multidisciplinary survivorship clinic at a VISN 1 conference in Bedford in July 2014 for providers and case managers in VISN 1 and for the national VA Survivorship breakout session at the annual AVAHO meeting in Portland, Oregon in September 2014 and it was very well received.

During 2014, I initiated an application for our Multidisciplinary Tumor Board participants to earn continuing education credits through Yale CME. This has been well received by staff, particularly our oncology nursing staff members who now rotate so that one nurse attends tumor board each week. I also took the initiative to link to Oncology Nursing Grand Rounds, a new monthly CME activity through our academic affiliate. Our nursing staff views the conference together via computer link and earns CME credits. I also continue to co-lead the monthly Oncology Nursing Journal Club which is a forum for ongoing education for nurses and other members of the

interdisciplinary team. Participants include staff from Nursing, Health Psychology, Oncology Pharmacy and Social Work. We also have colleagues in Vermont and throughout VISN 1 who call in. Nurses who are members of the Oncology Nursing Society earn continuing education credits by completing a short post-test about the article discussed each month. Of note, The Journal Club and Survivorship Care Plan were favorably noted as best practices by the Surveyor during a recent accreditation survey by the American College of Surgeons of our Cancer Center on June 6th.

*Julie Beck APRN-BC
Cancer Care Coordinator*

Case Management and Telehealth

The Case Management & Telehealth program is a proactive, integrated, collaborative case management model that utilizes an interdisciplinary team approach. The aim of the program is to provide proactive, high quality, timely care with a focus on health management. Telehealth modalities include Home Telehealth (HT), Clinical Store & Forward (CSF), and Clinical Video Telehealth (CVT). These services are available to improve access, provide timely interventions, and prevent unnecessary travel to the VA. Case managers are specially trained registered nurses and social workers that provide coordination of complex care needs for patients identified as high risk, high cost, or at high risk for decline.

The case manager is proactive in coordinating home and community based care services for skilled care needs including nursing, infusion therapy, medical social services; and physical, occupational and speech therapy; alternative care services including homemaking, home health aide, adult day care, and respite care; and palliative and hospice care. Care is communicated and coordinated with VA and non-VA providers, inpatient Patient Care Coordinators (PCC), Surgical Case Coordinators (SCC), Telehealth Care Coordinators (TCC) covering HT, and the interdisciplinary team to provide the right care, at the right time, in the right place, and at the right cost - each and every time.

Specialized case managers supporting the Cancer Program have training in using the Cancer Care Tracking System (CCTS). This web-based system allows for timely identification, tracking and monitoring of patients with abnormal radiology findings. The Case Management Society of America (CMSA) awarded VA Connecticut with the *CMSA Performance Improvement Award* for quality and performance improvement in cancer care coordination. VA Connecticut was recognized for 'innovation in the advancement of case management practice and improving timeliness of care by implementing specialized cancer care case management practice and a web based tool to improve patient safety and provider efficiency'.

*Donna C. Vogel MSN, CCM
Director, Case Management & Telehealth*

Chaplain Report

FY2014 Activity

- The Chaplains provide direct care/visitation to the in-patient population through routine visitations on the ward. As the circumstances/conditions change, the minimum 1x/wk. visits are increased to meet needs of the veteran and his/her significant others.
- The Chaplains provide a Ministry of Support and Presence to the Out-patient population – directly/personally, as called upon by the Veterans who come into our offices seeking our Services or in group activity such as the Cancer Survivor Day.
- Direct Chaplain Consultation/referrals are met within 24 hours, or less.
- As members of the Palliative Care Team, Palliative Care Consultation/referrals are met within 48 hours, or less.

- The Palliative Care Chaplain is a member of the Cancer Care Committee.
- The Palliative Care Chaplain is a member of the Cancer Survivor Committee.
- In addition to the .5 FTEE Chaplain assigned to the Palliative Care Team, our Service, when the Clinical Pastoral Program is in session (October-July), assigns a Chaplain Interns to the various units who provide additional coverage to the Hospice/Palliative Care in-patients.

Chaplain Mission Statement

- To serve the emotional, spiritual and religious needs of all VACT's patients by providing professional Chaplaincy and notifying, with patient consent, local clergy and religious leaders when needed.
- Our department is committed to a Culture of Caring and committed to helping patients utilize their spirituality as part of the healing process.
- Our department works with all people without regard to spiritual belief and/or religious tradition.

Background in caring for Patients and their Loved Ones

For patients or a patient's loved one, a hospitalization may raise profound spiritual questions:

- *Who am I in the midst of illness?*
- *What is my responsibility for my own wellbeing?*
- *What does "healing" mean?*
- *Do I have a reason to go on living?*
- *Where is my Higher Power / God in all of this?*

The chaplains know that these questions are a normal, even necessary, part of moving through an illness. While we cannot give answers to these questions, we are prepared to provide accompaniment and guidance as individuals seek their own answers.

Spiritual Care Referral Hours:

Mon. – Fri., 7:30AM - 3:30 PM

Sat. & Sun, 8AM-4:30PM

How to Contact: Patients currently in the hospital may request to see a Chaplain by speaking with their nurse or simply call ext. **2414** (for family members outside the hospital: **1.203.932-5711**, ext. **2414**).

Off tour hours Emergency:

For **inpatient emergency** only, the chaplains are to be contacted via VACT page operators.

At your request, we will exert every *reasonable* effort to contact the specific clergy of your choice.

*Sergei Bouteneff
Chief, Chaplaincy Service*

Clinical Health Psychology

At VA Connecticut, the Clinical Health Psychology service (CHP) takes a holistic, person-centered approach in working with veterans with cancer and their families. Clinical Health Psychology is focused on helping veterans improve their health and well-being. The CHP service works with Veterans to improve their physical health by learning self-management and behavioral strategies; learn how to cope better with their illness, and develop new, healthy habits. We can work with veterans individually, with their families, and in groups.

CHP offers services to help with:

- Coping with emotional reactions to cancer including depression and anxiety

- Pain management
- Stress management
- Managing nausea and fatigue
- Improving sleep
- Developing healthy habits like quitting smoking or making healthy lifestyle changes like healthy eating and exercise
- Using behavioral strategies to help veterans manage other health concerns like: diabetes, hypertension, or chronic pain problems
- Providing support groups for veterans with cancer

The following are the specific services offered by CHP within the Comprehensive Cancer Center:

- Individual CHP Clinics – for individual intervention and assessment. Current clinic times are
 - Tuesday afternoons from 1-4
 - Wednesday afternoons from 1-4
 - Wednesday mornings from 9-noon
- On the fly consultation and warm handoffs as availability allows.
- Living with Cancer Support Group
 - Bi-Monthly – 1st and 3rd Tuesday from 11:30-12:30

The following are the services offered through the CHP service that take place outside of the CCC:

- CHP assessments in Health Psychology/Primary Care clinic for bone marrow and stem-cell transplants
 - Friday mornings from 9-11AM in Firm B – by consult only
- Smoking Cessation Group
 - Friday afternoons from 1-2 in T3W conference room, building 2 – by consult OR drop in
- MOVE-IT
 - Mondays from 1-4PM in Firm A – by consult only
- MOVE Group
 - Mondays from 10-11:30 in T3W day room – drop in

Goals for 2015 are:

- Continue to offer individual and group services and education in the Cancer Center and the Survivorship Center.
- Continue to collaborate with the Cancer Center team to further develop programs in the Survivorship center based on ongoing needs assessment with veterans and staff.
- Continue to collaborate with the Cancer Center team and Patient Education team to develop educational materials for the veterans with cancer.

*Jessica Barber PhD
Clinical Health Psychology*

Clinical Oncology Pharmacist

At VA Connecticut Healthcare System, the clinical oncology pharmacist provides chemotherapy education and symptom management care for patients receiving chemotherapy treatment. Together with our oncology nurse practitioner Clarice Humanick APRN, we continue to review and update protocols in our electronic chemotherapy program Vista Chemotherapy Manager on a regular basis to assure that our templates are up to date and accurate. The oncology pharmacist is currently working with Pittsburgh VA Medical Center on a multi-site clinical trial evaluating adjuvant chemotherapy for stage III colon cancer (relative dose intensity and survival among veterans). The oncology pharmacist is a resource to the oncology multidisciplinary team, participates in monthly

nursing journal club, attends multidisciplinary tumor board, and maintains board certification in oncology pharmacy.

*John Szymanski, PharmD, BCOP
Clinical Oncology Pharmacist*

Clinical Research/Data Manager Report

The VA CT Cancer Center offers Veteran patients the opportunity to participate in clinical trials either at VA CT, or by referral to outside facilities if an appropriate trial is not available here. General information about clinical trials is available in the clinic area in the form of pamphlets and handouts, along with a list of websites to access trials for specific diseases.

The VA CT Cancer Center and its physicians have participated as members of the National Cancer Institute's Cooperative Group program since 2005, which allows access to a wide variety of studies which we may conduct at our institution. The VA CT Cancer Center is currently an affiliate member institution of SWOG (Southwest Oncology Group).

In 2013 the VA CT Cancer Center became part of the VISN 1 Clinical Trials Network (CTN). The mission of this network is to create an infrastructure and process for clinical investigation within VISN 1. The CTN, in collaboration with the VISN 1 Oncology Consortium, is selecting clinical research studies in oncology that will be opened at each of the VISN 1 facilities.

Individual sites often have limited access to clinical trials, especially industry sponsored trials, due to the small number of patients they can enroll; however, working with the CTN we will have the ability to open studies otherwise unavailable to Veteran patients at our site. Participation in the CTN will allow greater access to clinical trials for Veterans at VA CT and decrease the number of Veterans who must travel to other facilities to participate in a clinical trial. In collaboration with the CTN, we've added another Research Study Coordinator to our staff in 2014.

Our physicians are constantly searching for new clinical trials to conduct at our site, in order to meet the needs of our Veteran patients in the Cancer Center. One promising new clinical trial we will be conducting at our site is the SWOG study "S1400-Lung Master Protocol". Patients with a specific type of lung cancer will be screened to determine if their tumor contains certain genetic mutations known to be related to lung cancer. Based on the results of the screening, they will be assigned to a treatment group, which will use a "targeted" therapy, specific for the markers found in their tumor. They will be randomized either to the "targeted" therapy, or to the appropriate "standard of care" treatment for their lung cancer. This type of study allows patients to be screened for multiple treatment options at one time, instead of the old model of one experimental agent at a time, thereby allowing enrollment to the appropriate trial without delay.

Current Research Activities

Clinical Trials

Prostate Cancer

- "A Randomized Phase III Study of Neo-Adjuvant Docetaxel and Androgen Deprivation Prior to Radical Prostatectomy versus Immediate Radical Prostatectomy in Patients with High-Risk, Clinically Localized Prostate Cancer (CALGB 90203)" (P.I.: Charles Walker, M.D.)

- “The Men’s Eating and Living (MEAL) Study: A Randomized Trial of Diet to Alter Disease Progression in Prostate Cancer Patients on Active Surveillance” (CALGB 70807) (P.I.: Charles Walker, MD)
- “Imaging the Effects of Androgen Deprivation Therapy on Cognitive Functions in Patients with Non-Metastatic Prostate Cancer” (P.I.: Herta Chao, M.D., Ph.D.)

Lung Cancer

- “Randomized, Multicenter, Double-Blind, Phase 3 Trial Comparing the Efficacy of Ipilimumab in Addition to Paclitaxel and Carboplatin versus Placebo in Addition to Paclitaxel and Carboplatin in Subjects with Stage IV/Recurrent Non-Small Cell Lung Cancer” (BMS CA 184104) (P.I.: Herta Chao, MD, PhD)

Pancreas Cancer

- “Phase II Study of Modified FOLFIRINOX in Advanced Pancreatic Cancer” (P.I.: Jia Li, M.D., Ph.D.)

Hepatocellular Cancer

- “A Multicenter, Placebo-Controlled, Randomized Pilot Study of the Effect of Sorafenib on Portal Pressure in Patients with Cirrhosis, Significant Portal Hypertension and Hepatocellular Carcinoma Treated with Ablative Therapy and/or Transarterial Chemoembolization” (P.I.: Guadalupe Garcia-Tsao, MD)

Multiple Myeloma

- “A Phase 2 Biomarker Study of Elotuzumab (Humanized anti-CS1 Monoclonal IgG1 Antibody) Monotherapy to Assess the Association Between NK Cell Status and Efficacy in High Risk Smoldering Myeloma” (BMS CA 204011) (P.I. Ellice Wong, M.D.)

GI

- “Prospective Pilot study on role of Con-focal endoscopy in diagnosis of pre-malignant and malignant conditions of the GI tract” (P.I.: Anil Nagar, MD)

Health Outcomes

- “Effect of Pre-Existing Axis-1 Mental Health Conditions on the Timeliness of Care and Stage of Diagnosis of Solid Tumor Malignancies at the VA CT Healthcare System” (P.I.: Michal Rose, M.D.)
- “Electronic Hematology Consultations at VACT: Analysis of Effects on Patient Care, and Provider and Patient Satisfaction” (P.I.: Michal Rose, M.D.)
- “Incidence of Peripheral Neuropathy and/or Cognitive Dysfunction in Patients Receiving Mood Stabilizing Medications and Microtubule Dependent Chemotherapeutics” (P.I.: Herta Chao, M.D., Ph.D.)
- “Role of Virtual Colonoscopy in Colorectal Cancer Screening” (P.I.: Caroline Taylor, M.D.)
- “Colonoscopy for CRC screening: Role of inadequate prep of colon in colon polyp detection rates.” (P.I. Anil Nagar, M.D.)
- “Incidental Positive PET scans in the GI tract.” (P.I. Anil Nagar, M.D.)

Molecular biomarkers

- “Functional and Molecular Correlates of Myelodysplasia” (P.I.: Natalia Neparidze, M.D.)

*Monica Delvy
Clinical Research/Data Manager*

Nutrition/Dietary Report

There are several nutrition services offered to cancer patients. Nutritional counseling with a registered dietitian (RD) is offered depending on patient’s therapeutic needs (high calorie, high protein) in the Oncology Clinic, Outpatient Nutrition Clinic and/or by inpatient RDs. The RD will assess a patient’s current diagnosis, past medical history, labs to determine diet needed (either low cholesterol, low sodium, NCS, low K+, etc.).

While inpatient there are a variety of supplements (high calorie, high protein, diabetic) that can be given to help meet a patient’s calorie and protein needs from the stress a cancer diagnosis can have on an individual. Besides supplements, inpatient RDs can talk to patients and see what food preferences they may have and try to give a variety of snacks per patient request. In patients who are unable to eat by mouth, commonly due to head and neck cancer or esophageal, tube feeding can be initiated, if there is a functioning GI tract. On the other hand, if a patient has gastrointestinal complications, TPN or PPN may be offered. Nutritional services offer a variety of tube feedings such as elemental, high fiber, high calorie, and low K+ (for renal patients). Upon discharge, patients may be referred to the outpatient nutrition clinic for follow-up.

A tube feeding may also be initiated on an outpatient basis, if there is a functioning GI tract. The RD will assess the patient and provide nutrition recommendations. Outpatient RDs can work with patients to develop a tube feeding schedule that can safely fit into their lifestyle (bolus, gravity drip, continuous or combined feeds) as appropriate. If any of these tube feedings do not meet patients’ therapeutic needs on an outpatient basis, a non-formulary drug request could be written. Moreover, if a patient has head or neck cancer and is lactose intolerant he/she may be eligible to receive the oral supplement (Boost Plus) through the VA.

There are support groups and classes provided for patients with cancer. Classes generally ranges 1 hour to 1.5 hours and provide tips for enhancing po intake, discusses supplements and reviews overall healthy eating tips before, during and after cancer treatment.

*Jennifer Jay MS, RD, CD-N
Clinical Coordinator*

Oncology Education and Support

Oncology education for patients and nurses continues to be an important part of my role here at VACT. I continue to work on developing nursing policies and procedures to guide both inpatient and outpatient oncology patient care using guidelines by the Oncology Nursing Society (ONS) and other established organizations. I conduct annual chemotherapy proficiencies with the chemotherapy nurses. Together with our clinical pharmacist Dr. John Szymanski, we review protocols and Vista Chemotherapy Manager (VCM, our electronic chemotherapy program) issues on a regular basis to assure that our templates are up to date and accurate. I continue to be a resource to the chemotherapy nurses and ancillary staff regarding all issues of chemotherapy administration,

clinic schedule and coordination of complex patient care. I am involved in the monthly Journal club and give 5 talks per year to cancer center staff, as well as ancillary staff at VACT. I

I continue to be member of the VHA ONS Oncology Field Advisory Committee. We are working on a national LMS project to help nurses and nurse managers learn chemotherapy nursing and develop competencies. We have completed a handbook in LMS titled, "Core Competencies in the Administration of Chemotherapy and Biotherapy." I have also worked on oncology standard operating procedures, cancer survivorship toolkits, cancer coordination, which are all Clinical Practice Program (CPP) products and under the Office of Nursing Services.

I am working with Dr. Herta Chao on a study looking at the incidence of peripheral neuropathy and/or cognitive dysfunction in patients receiving mood stabilizing medications and microtubule dependent chemotherapeutics.

I am certified as a Psychiatric Mental Health Nurse Practitioner (PMHNP). I also remain board certified as a Family Nurse Practitioner (FNP). I continue to participate in educational conferences both for oncology and psychiatry. I continue to be the liaison between Coram, the outside agency with whom we contract to deliver continuous chemotherapy infusions for our Veterans, and the VA, and this process functions seamlessly. I continue to be certified in oncology by the Oncology Nursing Society (ONS) and have a chemotherapy and biotherapy card, which is also issued through ONS every two years. I continue to participate in our local oncology chapter and participate in outside activities to support oncology, which include breast cancer survivorship walk, sponsored by the American Cancer Society.

Goals and Objectives for 2015:

1. Continue to troubleshoot and improve VCM while working with the company closely.
2. Expand the role of psycho-oncology in our clinics. Psycho-oncology is one of the most clearly defined sub-specialties of consultation-liaison psychiatry, and is an example of the value of a broad multidisciplinary application of the behavioral and social sciences.
3. Expand my knowledge on end-of-life care.
4. Complete above study with Dr. Chao
5. Update cancer coordination on the Office of Nursing Services products page.

*Clarice Humanick MSN,AOCN,FMP
Oncology Education & Support*

Palliative Care/Hospice

VA Connecticut has been offering Hospice & Palliative Care services in a variety of different capacities for a number of years. Starting with the initiation of the VACT Hospice and Palliative Care Task Force in 2003, there has been a sustained effort to improve and expand the delivery of hospice/palliative care services throughout VA Connecticut consistent with VHA National goals and directives to achieve excellence in hospice & palliative care. VA Connecticut's goal for palliative care continues to be to prevent and/or alleviate suffering while promoting dignity and providing support for the best possible quality of life for both Veterans and their families, regardless of the disease or the need for other therapies. Palliative care is operationalized by an interdisciplinary team through effective management of pain and other distressing symptoms, while incorporating

psychosocial and spiritual care according to the Veteran/family needs, preferences, values, beliefs and culture. The following resources are available to meet the needs of Veterans with life-limiting illnesses including: Palliative Care Consultation Team (PCCT), the Hospice Veteran Partnership (HVP) of Connecticut, Comprehensive Pain Management Team, inpatient hospice and respite programs on the Community Living Center (CLC), chaplain services, care coordination/case management services, social work, patient care coordinators, recreational and creative arts therapists, nutrition and pharmaceutical services, rehabilitation therapy (PT, KT and OT), and Home Based Primary Care (HBPC) to bridge to home hospice and community hospice services.

Both VISN 1 and VACT continue to have strong involvement in excellence in end of life care for our Veterans. In regards to palliative care consults, VISN 1 went from 350 palliative care consults in FY 2005 to 1896 palliative care consults in FY 2014. The VACT Palliative Care Consult Team continues to show remarkable growth. The team went from 29 consults in FY05 to 377 in FY14. In addition, in FY05 only 18% of the patients received a palliative care consult prior to death; 79% of the inpatient deaths in FY14 had received a palliative care consult. Most veterans are followed longitudinally with the time frame from consultation to death moving earlier in the Veteran's disease course. Even though the consults continue to grow, the team strongly feels that only a small percentage of Veterans that are eligible and in need of these services are currently being followed. It is anticipated that with ongoing expansion of dedicated Palliative Care Consultation Team staffing, this number will only continue to rise. Another positive trend that is happening at VACT is the number of deaths in the ICU or acute care settings is decreasing and conversely, the number of patients on the CLC in TS96 (hospice & palliative care treating specialty) are increasing. The palliative care team services Veterans in all inpatient venues as well as the outpatient oncology clinic, ALS multidisciplinary clinic and once weekly outpatient clinic for additional outpatient availability to Veterans without a cancer diagnosis. This includes as needed co-management in the CHF/cardiology and pulmonary clinics. As a result of these efforts, patients are now being identified earlier in their disease process, which means the team is often able to significantly improve distressing symptoms that leads to improved quality of life. The PCCT team also has representation at the pulmonary/ENT tumor board in a continued effort to try to identify patients who may be in need of services. Additionally, the PCCT established a family meeting template for use in all inpatient venues, and have been working cooperatively with our MICU staff with a goal of improvement in timeliness of family meetings in critical illness. Over the past year, the No Veteran Dies Alone hospice volunteer program was successfully rolled out on the Community Living Center.

During the past few years, the CLC continues on their cultural transformation journey in an effort to enhance quality of life, preserve dignity and promote personal choice of Veterans. Since this project was undertaken, all of the patient rooms and hallways were painted brighter colors, ambient lighting was added to a corridor of rooms, seasonal landscape pictures have been purchased, and individualized DVD and CD players are available for use. Chairs that convert to twin beds have been added to each room in the palliative care wing to allow more comfortable accommodations to families who choose to remain here overnight with their loved ones. A new family education and bereavement room was constructed and furnished. Comfort carts have been added to provide coffee/tea and non-perishable snacks to family members. To provide comprehensive palliative and end of life care, there is an increased emphasis on non-medical modalities for relief of suffering. This has included increases in available music therapy and physical/occupational therapy with the addition of a second kinesiologist. In addition, given the larger volume of hospice/palliative care patients that are being admitted to the CLC, it was felt that more formalized hospice training for the

staff was necessary. Web-based educational modalities are being used to facilitate palliative & hospice education to all members of the clinical and nursing staff.

Bereavement support continues to be an important aspect of follow up care not only for the family members of the deceased Veterans but also to the staff that have cared for these individuals. The hospice and palliative care service has developed a number of different programs to assist with this aspect of care. Since 2007, this program has been providing an interfaith memorial service that memorializes Veterans who have died in the following programs: Community Living Center, Home Based Primary Care, Oncology service, OEF/OIF/Operation New Dawn, ALS/SCI and the hemodialysis unit. Originally the services were held twice a year but given the large percentage of deaths, the services now occur quarterly. The hope is to expand the services to include any Veteran who dies in any of the inpatient, outpatient or home and community based programs. Starting FY15, all Veterans who die in the inpatient setting at VACT irrespective of whether they have been served by Palliative Care Consultation Team (PCCT) will be included. The PCCT, Community Living Center, Home Based Primary Care (HBPC), & SCI/ALS programs are also included in the bereavement letter support program for families of the deceased. Specialized letters addressing various aspects of grief and bereavement is sent to participating family members at specified time intervals to help provide education and support. This has been expanded through the Caregiver Support program to include all Veterans who die at VACT. Families are also provided with information on community bereavement programs. A specialized memorial corner where deceased patients can be memorialized by family and staff has been created in an alcove on the Community Living Center. Monthly and as needed, there is a staff support group led by social work and chaplaincy given the high caregiver burden of serving this population. Recently there has been education & in-servicing with staff on compassion fatigue.

On January 30, 2006, a steering meeting to launch the Hospice Veteran Partnership (HVP) of Connecticut was held at the Connecticut Hospital Association in Wallingford. The event was sponsored by the VA Connecticut Healthcare System, the Connecticut Council for Hospice and Palliative Care and Rocky Hill. The HVP of Connecticut is a coalition of individuals and organizations whose mission is to establish an enduring network of hospice and VA professionals, volunteers, and other interested organizations working together to provide quality services through the end of life for all of our state Veterans and their families. Connecticut is one of many states that have organized Partnerships and are a part of the national network of Hospice Veteran Partnerships. The Partnerships are an important part of the initiative by the Department of Veteran Affairs and the Veteran Health Administration that has made high quality end-of-life care a priority. The HVP of Connecticut has provided several educational conferences to date as well as various conferences throughout the state that deal with specialized issues such as PTSD and end of life. The HVP has received several grants; one from the National Hospice and Palliative Care Organization for \$25,000 and two VA Rural Health Grants (one for \$57,000 and one for \$61,000) to develop a specialized curriculum for training Veterans to become hospice volunteers to other Veterans in rural areas.

*Linda Accordino APRN
Manager, Geriatrics & Extended Care*

Pathology and Laboratory Medicine Report

The pathologists review tissue and fluid samples from inpatients and outpatients. The pathologist will contact the clinicians in all cases of new malignancies or in other cases of unexpected findings of immediate clinical significance. The final report describes the type of cancer, its size, grade and

extent. If appropriate, the cancer is staged using the American Joint Committee on Cancer staging. If the tumor is rare the case may be sent for expert consultation, usually to Yale-New Haven Hospital or to the Joint Pathology Center, a Federal reference laboratory. Modern anatomic pathology requires selection among a variety of techniques to characterize tumors, including immunohistochemistry, flow cytometry, and molecular diagnostics. While these techniques are largely performed outside of VACT, overall interpretation and integration of the reports is still the responsibility the local pathologist. The pathologists present cancer cases at tumor board conferences. Dr. Homer, the Director of Anatomic Pathology, is an active participant of the Cancer Committee. Our staff includes Dr. Xuchen Zhang, an expert in GI and lung pathology, Dr. Alexa Siddon, an expert in hematopathology, Dr. Susan Fernandez, an expert in cytology, including performance of fine needle aspirates, Dr. Robert Homer, with 20 years' experience at the VA and with expertise in lung and general surgical pathology, Dr. Susan Gobel, with expertise in cytology, GI and GU pathology and Dr. Richard Torres, an expert in hematopathology. Drs. Homer, Siddon, Zhang, Fernandez and Torres all practice at Yale as well as at the VA.

*Robert Homer M.D. PhD
Director of Anatomic Pathology, Pathology and Laboratory Medicine Service*

Patient/Family Education

Education programs and support groups are offered to Veterans and their families at the VACHS. Veteran/family education programs are based on patient preferences/needs and may include:

- Discussions with health care disciplines with regard to patient education needs, community resources.
- Health maintenance/screening and cancer related materials that patients and families may view at the medical center or at home.
- Closed Circuit Television. Examples of the films available include pain control, coping with cancer, and cancer care. A video lending library is available for patients who prefer to view films at home. Cancer related programs: C.A.R.E Channel (34 and 35) Patient Health Channel (36): Preventing Colon Cancer, Living with Prostate Cancer, Lung Cancer: Improving Survival, Advanced Directives: Making Family Decisions, many chronic disease management as well as wellness/prevention programs. 24/7.
- C.A.R.E.Channel – provides a continuous relaxing environment for patients/families.
- Structured classes are available that are geared to pain control, nutrition, prevention and exercise.
- Patient/Family Education Learning Center which offers a section specific to cancer related subjects and an area to view cancer related videos.
- Use of Clinical Video Telehealth (CVT) to offer education programs to wider audience at VACHS and VISN locations.
- Patient Newsletter – includes health topics on cancer screening, prevention.

Prevention and cancer education related programs:

Colonoscopy pre-screening education program - offered weekly with five-one hour sessions. Advanced directives are obtained at the sessions. A new colonoscopy preparation video developed by endo team will be used in the education sessions, very informative.

Amputee Education/Support Group – Support group meets weekly, once a month education session is provided with topics including smoking cessation, cancer screening, and sessions covering prostate cancer, breast cancer in men, lung cancer, and skin cancer prevention.

Patient Newsletter: Focus on Cancer Prevention topics on different months. Display for cancer prevention at the Patient Learning Center, room 1-300 offered x 2 in 2014.

Health Promotion, Disease Prevention (HPDP): 9-core healthy living messages delivered to patients/staff including tobacco cessation, eating wisely, physical activity, screening procedures. Monthly education sessions focusing on the core elements of healthy living, stress management, coping, relaxation techniques.

Stanford Chronic Disease Self-Management Program (CDSMP): “LIVEWELL” program to focus on self-management of chronic disease, pain relief measures, peer to peer support and education; six-sessions.

Veteran Pain Education Program (V-PEP) – offered weekly, CVT to Newington, Contact Dana Cervone, APRN.

Caregiver Support Group – every other week, contact Dana Savo, RN

Living with Loss – Grief and Support Education Group, monthly, contact Dana Savo, RN

Community Outreach:

Madison Senior Center – presentation 5/29/14 on healthy living, cancer prevention, programs offered at VACHS for wellness and chronic disease self-management.

Healthy Living Fair – 4/16/14 – open to Veterans, families, staff, community. Information provided on healthy living, cancer prevention/early detection, nutrition, safety, community resources, programs offered at VACHS, My Healthe Vet, pain management, and more. Over 140 attended.

Cancer Survivor Day – 9th annual celebration - 6/13/14 – open to Veterans, families, staff, community. Focus on health, wellness, prevention, humor. Guest speakers, included Bernie Siegel MD, Kent Pierce (Action 8 News). 170 attended throughout the 4.5 hour program.

Goals for 2014:

- Increase attendance to cancer related education programs
- Continued collaboration with American Cancer Society, Leukemia and Lymphoma Society
- Plan annual Cancer Survivor Day, June, 2015 (10th Annual)
- Plan Healthy Living Fair, April, 2015
- Planning patient education programs based on Veteran/family need.

- Use of Clinical Video Teleconferencing to provide prevention/health promotion programs to reach wider audience in CBOCs
- Plan staff cancer education program, 2015, focus on women's health
- Continue with community outreach programs

*Jacquelyn Wolf MSN, RN, CDE
Veteran and Family Education Coordinator
My Health Vet Point of Contact*

Physical Medicine and Rehabilitation

Cancer is a category of disease that may lead to changes in physical functioning and ability to manage activities of daily living (ADLs). Rehabilitation professionals, including Physical Therapists, Occupational Therapists, and Kinesiotherapists, are able to assist veterans affected by cancer, to help them maximize independence and quality of life within their medical status. The goal of Cancer Rehabilitation is to help patients and survivors restore, improve and maintain physical, psychological and vocational function that has been impacted by their illness and by cancer therapies.

Physical and Occupational Therapy services available include:

- Pain Management: modalities including moist heat, cold therapy, TENS (Transcutaneous Electrical Nerve Stimulation), and ultrasound treatments.
- Equipment provision and training to facilitate safe visits or discharge to home.
- Fall Prevention assessment and treatment to improve safety with transfers and ambulation.
- Education for patients and families in safe and proper use of assistive devices and adaptive ADL equipment to facilitate and encourage increased patient independence.
- Lymphedema assessment, treatment and patient/family training in techniques for bandaging and lymph massage.
- Home Exercise Program designed to maintain and improve range of motion, strength and general endurance.
- Recommendations for continued rehabilitation service needs after discharge home, such as home PT or OT, or modifications to the home to accommodate change in level of mobility.

Rehabilitation Services are available both to both inpatients and outpatients. Providers may send consults to Physical Therapy Oncology or Occupational Therapy Oncology Clinics for outpatient evaluations or to Physical Therapy inpatient or Occupational Therapy inpatient for veterans on acute or palliative care services. We can also be reached at 203-932-5711 x 7250 or 2509.

*Mary Dallas, PhD, PT
Laurie Wingard PT, GCS
Physical Medicine and Rehabilitation*

Radiation Oncology

When VA cancer patients require radiation therapy they are referred to the Yale-New Haven Hospital. Radiation Oncologists from the Yale School of Medicine, Department of Therapeutic Radiology are actively involved in the VACT multidisciplinary tumor board. All new consults are seen within 5 days. The Department of Therapeutic Radiology provides a wide range of specialized radiation techniques including the intensity modulated radiation therapy (IMRT), image-guided

radiation therapy (IGRT), gamma-knife radiosurgery for intracranial tumors, linac-based stereotactic body radiosurgery (SBRT) for tumors of the lungs, liver and spine, and brachytherapy. The department is actively involved in research protocols offered both by cooperative groups and Yale University investigators. An attending physician and a resident from radiation oncology participate in tumor board and work closely with VA physicians to coordinate care.

*Bryan Chang M.D.
Radiation Oncology*

Radiology

The Diagnostic Imaging Service of VACT offers comprehensive imaging services with general radiology, CT (2 64 slice multidetectors, with a pending replacement with a 320 slice scanner suitable for advanced cardiac and vascular applications, and perfusion imaging), and new software which will enable further radiation dose reduction in both scanners. We offer body and neuroMR (we have 2 scanners, 1.5T and 3T field strength) and state-of-the-art ultrasound and angiography equipment.

We offer fine needle aspirations of accessible lesions of lung, visceral organs, retroperitoneum, head and neck and spine and offer radiofrequency ablation of tumors, including liver, lung and kidney, and have instituted a new program offering chemoembolisation of liver tumors. We also are able to perform cryoablation procedures, used mainly in treatment of kidney tumors. Diagnostic and interventional angiography includes peripheral vascular, carotid, aortic and other stent procedures. We offer CT of the coronary arteries, CT arteriography, CT urography and virtual colonography (we have participated in an ACRIN trial in addition to performing studies on patients who are unable to undergo a completed endoscopy). In addition to offering “completion virtual colonography” to patients on the same day as an incomplete optical colonography, virtual colonography can also be offered as a screening alternative in patients who have relative contraindications to optical colonography, such as those at high risk of complications from sedation, or requiring anticoagulation therapy which should not be discontinued. We are involved in a screening program of patients with hepatitis C and cirrhosis. Mammography is referred off site, with incorporation of reports into the electronic medical record, and patients needing subsequent procedures such as ultrasound and MRI/biopsy are also referred for care to external MQSAP qualified programs. We have implemented NCCN guidelines recommending low dose CT lung cancer screening to high risk patients who are heavy smokers or ex-smokers, in collaboration with Primary Care, who in May 2013 deployed a new clinical reminder developed in association with the IT service, with multidisciplinary cancer management of confirmed cases, and increased focus on smoking cessation for enrollees, as appropriate. We are screening up to 200 patients per month.

The service can offer advanced image guided pain management procedures, such as deep nerve blocks and vertebral kyphoplasty for compression fractures.

Newington campus offers general radiography, DEXA scanner, and ultrasound services available on site.

We offer nuclear medicine diagnostic services in general nuclear medicine and cardiac nuclear medicine (in association with the Cardiology Section), and therapeutic procedures. We have a PET-CT scanner and a new SPECT CT installed since 2011, suitable to dedicated oncologic imaging. We have increased our capacity in this area so essential in cancer care, in addition to offering functional

cardiac evaluations through the Department of Cardiology, and neuroPET in evaluation of dementia. We have the capability to deploy radiation planning software integrated with the PET-CT images. Fusion software facilitates reading our PET scans integrated with CT scans and providing these images on the PAC's workstation. We offer targeted therapy with Ibritumomab Tiuxetan, which is a radiotherapeutic antibody administered for the treatment of patients with relapsed or refractory low grade lymphoma and previously untreated follicular lymphoma who achieve a partial or complete response to first – line chemotherapy. We also offer radioiodine therapy with Iodine 131 and follow up imaging for patients with thyroid cancer, and therapy for refractory painful bone metastasis with Samarium 153. In addition we offer therapy with radium 223 dichloride for patients with castration-resistant prostate cancer (CRPC) with symptomatic bone metastases and no known visceral metastatic disease. All our studies, including nuclear medicine, are available on the PACs network and web servers available to the clinicians.

Our radiologists include specialists available on a daily basis to consult on neuroradiology, general radiology, and cross-sectional and interventional procedures. We participate in the general, head and neck, pulmonary and liver tumor board conferences and multispecialty conferences such as GI, urology on a weekly basis. We train residents in Diagnostic Radiology, Nuclear Medicine (Diagnosis and Therapy), and Interventional Radiology.

We have offered TACE (transarterial chemoembolization) for patients with liver cancer since September 2009.

We accept referrals from other VA medical centers for the above procedures.

*Caroline Taylor M.D.
Chief, Radiology*

Social Work Services

Social Work service is available to all patients involved in VA Connecticut's Oncology program. Outpatient social work service is available to patients during their clinic visit (Donna Doris, Ext. 3710). Ongoing social work case management is also offered based on the Veteran's primary care team social worker.

Social work offers comprehensive psychosocial evaluation and case management services.

An effort to enhance the Veteran's social and psychological well-being is accomplished through a variety of modalities and interventions.

- Entitlements: Assistance with securing benefits such as Social Security Disability, Medicare, or Title XIX.
- Transportation: Connecting veterans with transportation resources. Referrals include VA sponsored travel offering chair car transportation to eligible Veterans; DAV and other Veteran's service organization's volunteer efforts. American Cancer Society and other non-profit organizations. State and local paratransit services such as "My Ride".
- Disposition Planning: Social work assists in arranging skilled nursing or rehabilitative care as well as inpatient/ outpatient Hospice care.
- Patient and Family Education: Identification and referral to services and programs available through the VA as well as community. A number of educational brochures are available pertaining to Advance Directives, travel and other supportive services.

- Supportive Counseling: Veterans and their families receive counseling to assist with coping with diagnoses as well as other stress. Recommendation or referral to health psychology or mental hygiene as appropriate.
- Social Work is available to assist Veterans who are in cancer treatment with their unique psychosocial needs.
- Support Group: Social work participates in all oncology focused group series, facilitating group discussion and encouraging peer support. Social Work coordinates a bimonthly support group for Caregivers of Veterans Living with Cancer.
- Other Resources: Veterans who require early morning appointments, appointments scheduled for consecutive days or are traveling far distances can remain in a VA contracted hotel.
- Other: Social Work participated in the planning committee and provided educational material at the Annual Cancer Survivor Day celebration at VA Connecticut in 2014.

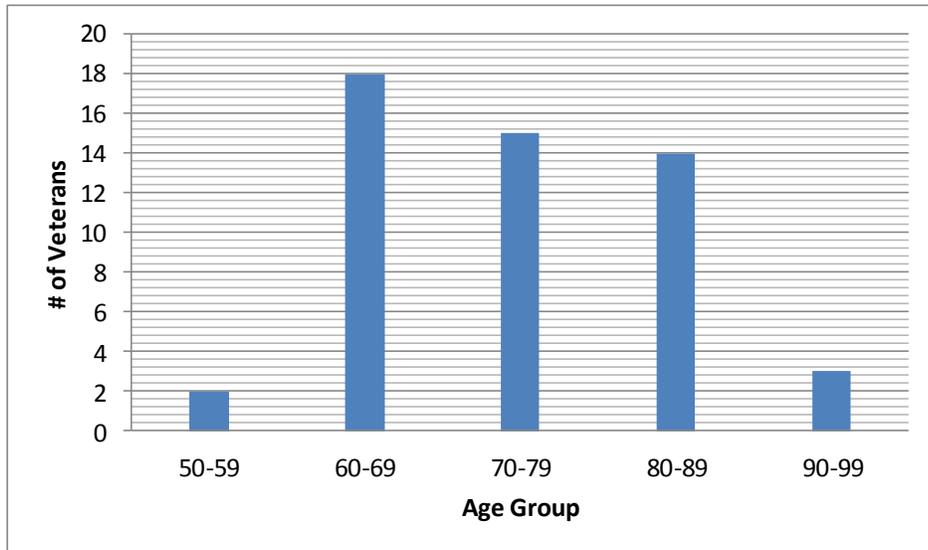
*Donna Doris LCSW
Social Work*

PRIMARY SITE TABLE 2013 DATA												
SITE:	TOT#	ANAL	NON	M	F	0	I	II	III	IV	U	NA
LIP	1	1		1		1						
TONGUE, BASE	2	2		2						2		
FLOOR OF MOUTH	2	2		2			1			1		
PALATE	1	1		1					1			
OTHER/NOS MOUTH PARTS	1	1		1				1				
TONSIL	5	5		5				1	2	2		
OROPHARYNX	1	1		1						1		
HYPOPHARYNX	1	1		1					1			
SUBTOTAL	14	14	0	14		1	1	2	4	6	0	0
ESOPHAGUS	12	12		11	1		2	4	2	2	2	
STOMACH	6	6		6			1	2		3		
SMALL INTESTINE	5	5		5				2	1	1		1
COLON	17	16	1	17		4	3	2	4	3	1	
RECTOSIGMOID JUNCTION	1	1		1				1				
RECTUM	7	7		7			2	1	3		1	
LIVER/INTRAHEPATIC BIL	26	22	4	26			12	8	3	3		
BILARY TRACT - OTHER/N	1	1		1			1					
PANCREAS	12	11	1	12			1		4	7		
SUBTOTAL	87	81	6	86	1	4	22	20	17	19	4	1
LARYNX	8	8		7	1		1	1	2	4		
LUNG/BRONCHUS	119	115	4	114	5		46	16	22	29	6	
HEART/MEDIASTINUM/PLEU	2	1	1	2				1		1		
SUBTOTAL	129	124	5	123	6	0	47	18	24	34	6	0
HEMATOPOIETIC/RETICULO	47	46	1	45	2					2	1	44
SUBTOTAL	47	46	1	45	2	0	0	0	0	2	1	44
SKIN	83	63	20	82	1	38	31	4	2		6	2
SUBTOTAL	83	63	20	82	1	38	31	4	2	0	6	2
RETROPERITONEUM & PERI	1	1		1			1					
SUBTOTAL	1	1	0	1		0	1	0	0	0	0	0
CONNECTIVE/SUBCUTANEOU	3	3		3			1	1	1			
SUBTOTAL	3	3	0	3		0	1	1	1	0	0	0
BREAST	5	3	2	1	4	1	2	1	1			
SUBTOTAL	5	3	2	1	4	1	2	1	1	0	0	0
CORPUS UTERI	1	1			1			1				
SUBTOTAL	1	1	0		1	0	0	1	0	0	0	0
PENIS	3	3		3		3						
PROSTATE GLAND	145	141	4	145			32	96	2	10	5	
TESTIS	3	3		3			1			1		1
MALE GENITALIA, OTHER/	2	2		2			2					
SUBTOTAL	153	149	4	153		3	35	96	2	11	5	1
KIDNEY	25	25		25			18		3	4		
RENAL PELVIS	3	3		3		3						
URETER	1	1		1		1						
BLADDER	51	48	3	51		31	10	5		4	1	
SUBTOTAL	80	77	3	80		35	28	5	3	8	1	0
MENINGES	1	1		1								1
BRAIN	5	5		5								5
SP CORD,CRANIAL NERVES	1	1		1			1					
SUBTOTAL	7	7	0	7		0	1	0	0	0	0	6
THYROID GLAND	5	5		4	1		3	1			1	
SUBTOTAL	5	5	0	4	1	0	3	1	0	0	1	0
LYMPH NODES	9	9		9			5		2	2		
SUBTOTAL	9	9	0	9		0	5	0	2	2	0	0
UNKNOWN PRIMARY SITE	12	12		12								12
SUBTOTAL	12	12	0	12		0	0	0	0	0	0	12
TOTAL	636	595	41	620	16	82	177	149	56	82	24	66

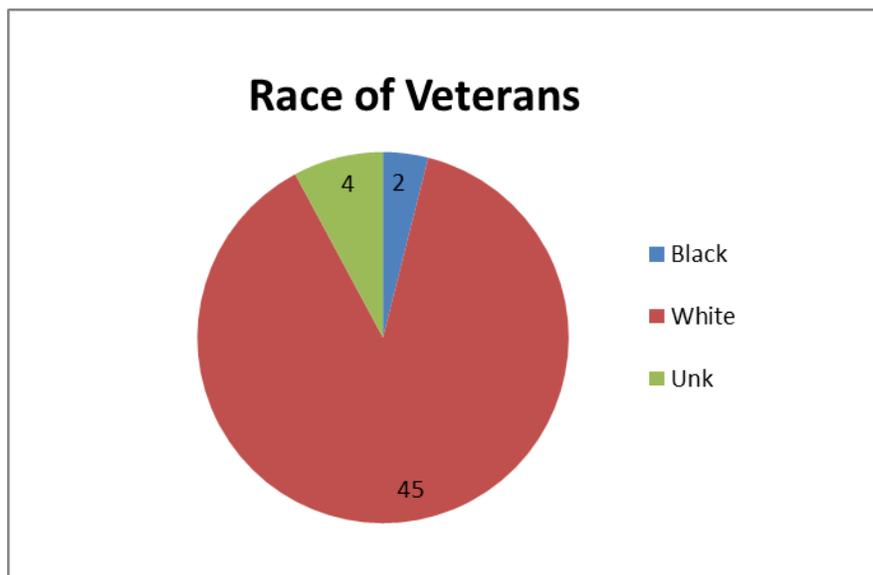
BLADDER CANCER – VACT 2013
Michal G. Rose MD, Preston Sprenkle MD, Donna Connery CTR

In 2013, 51 Veterans were diagnosed at VA Connecticut Healthcare System with bladder cancer. The median age was 71 years with a range of 53 to 94 years. All were male.

AGE AT DIAGNOSIS

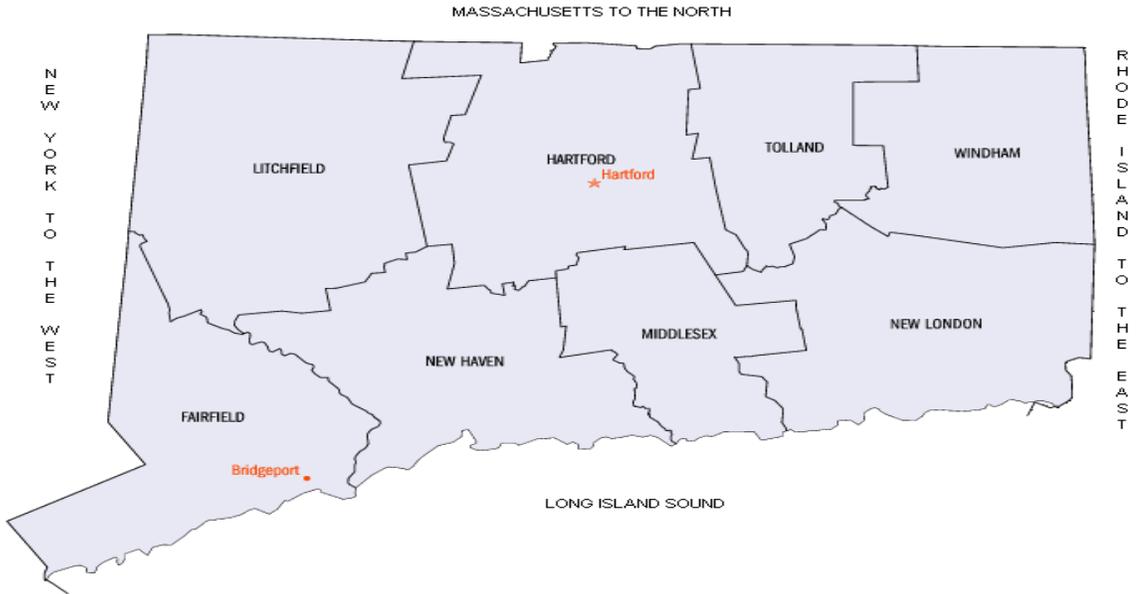


Of the 51 Veterans diagnosed at VACT Healthcare System with bladder cancer in 2013, 45 Veterans (88%) were white, 2 Veterans (4%) were black, and 4 Veterans (8%) had no race documented.



Comparison Data/State of CT

Number of Cases Diagnosed by County 2007-2011

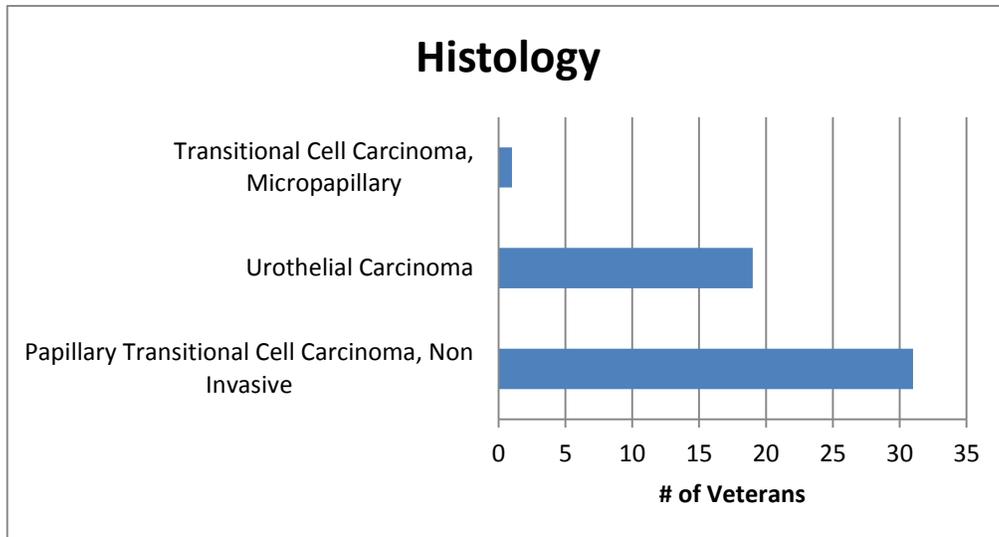


	2008	2009	2010	2011	2012	Total
Fairfield	297	271	258	272	273	1371
Hartford	302	258	314	267	303	1444
Litchfield	62	71	69	95	73	370
Middlesex	49	51	70	67	68	305
New Haven*	241	289	288	271	299	1388
New London	90	98	79	118	88	473
Tolland	35	36	36	44	39	190
Windham	38	37	32	34	36	177
Total	1114	1111	1146	1168	1179	5718

* Cases from VA Connecticut are included in New Haven County

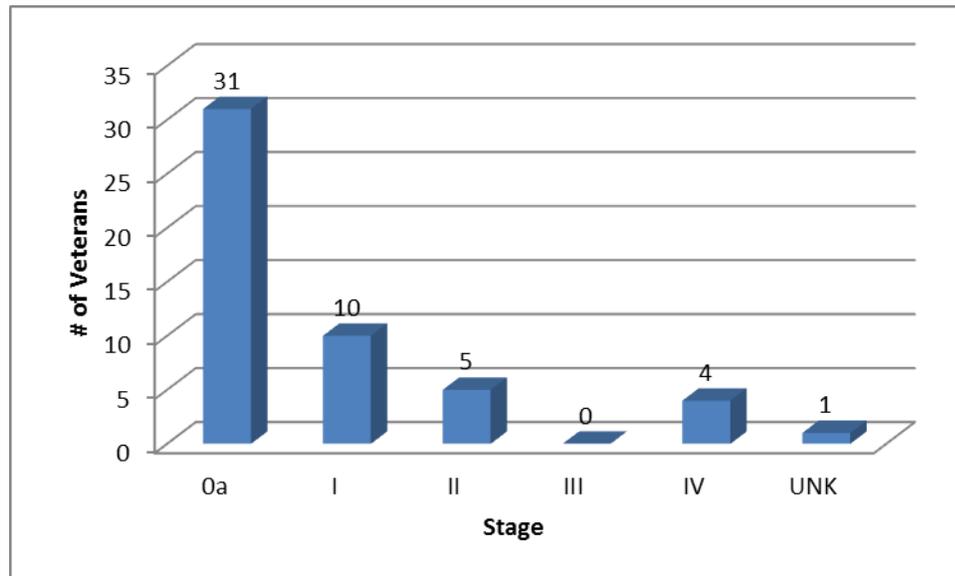
HISTOLOGY 2013 Data

Of the 51 Veterans diagnosed at VACT Healthcare System with bladder cancer in 2013, 31 Veterans (60%) were diagnosed with papillary transitional cell carcinoma, non-invasive, 19 Veterans (38%) were diagnosed with Urothelial Carcinoma, and 1 Veteran (2%) was diagnosed with Transitional Cell Carcinoma, Micropapillary.



STAGE AT DIAGNOSIS 2013 Data

Of the 51 Veterans who were diagnosed with bladder cancer in 2013, 31 Veterans (60%) were diagnosed with Stage 0, 10 Veterans (20%) were diagnosed with Stage I disease, 5 Veterans (10%) were diagnosed with Stage II disease, 0 Veterans (%) were diagnosed with Stage III disease, and 4 Veterans (8%) were diagnosed with Stage IV disease. There was 1 Veteran (2%) with an unknown stage.



COMPARISON DATA VA CONNECTICUT VS STATE VS NCDB, 2000 – 2011 Data

STAGE AT DIAGNOSIS

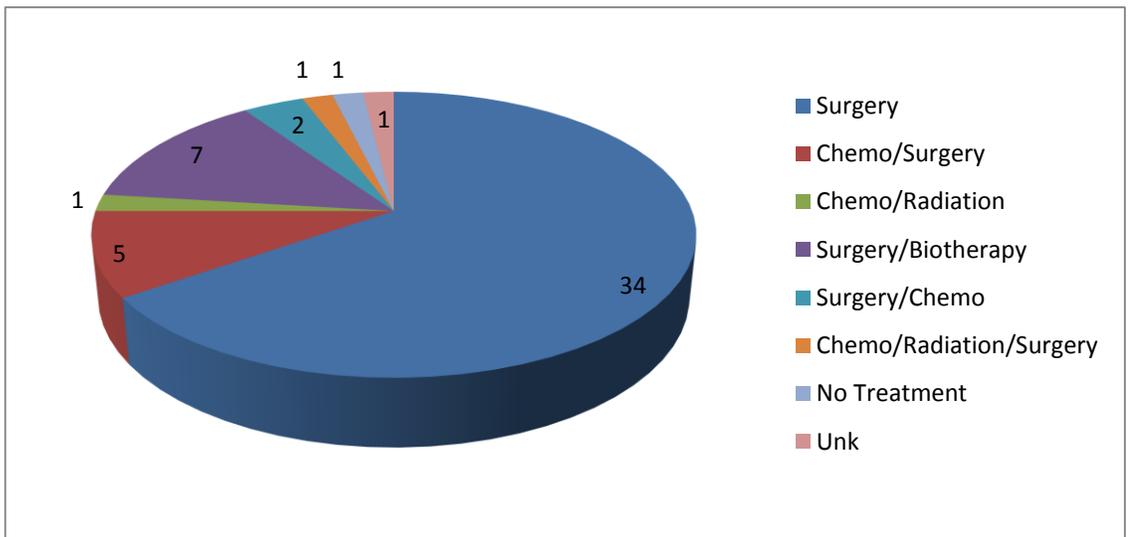
VA Connecticut Healthcare System vs. State of CT vs. NCDB “All Hospital Types” vs. all VAs
vs.

State of Connecticut Data is 2004-2011 – AJCC not recorded in SEER prior to 2004

STAGE	VACT (N)	STATE (N)*	NCDB (N)	All VA (N)	VACT (%)	STATE (%)*	NCDB (%)	All VA %
0	162	3149	166576	10334	47	55.1	46.89	44
I	86	1239	73908	6292	25	21.7	20.8	27
II	27	609	40645	2300	8	10.7	11.44	10
III	16	193	17045	930	5	3.4	4.8	4
IV	34	358	24431	1756	10	6.3	6.88	8
NA			504	30			.14	.01
UNK	19	170	32157	1699	5	3.0	9.05	7
Total	344	5718	355266	23342	100	100	100	100

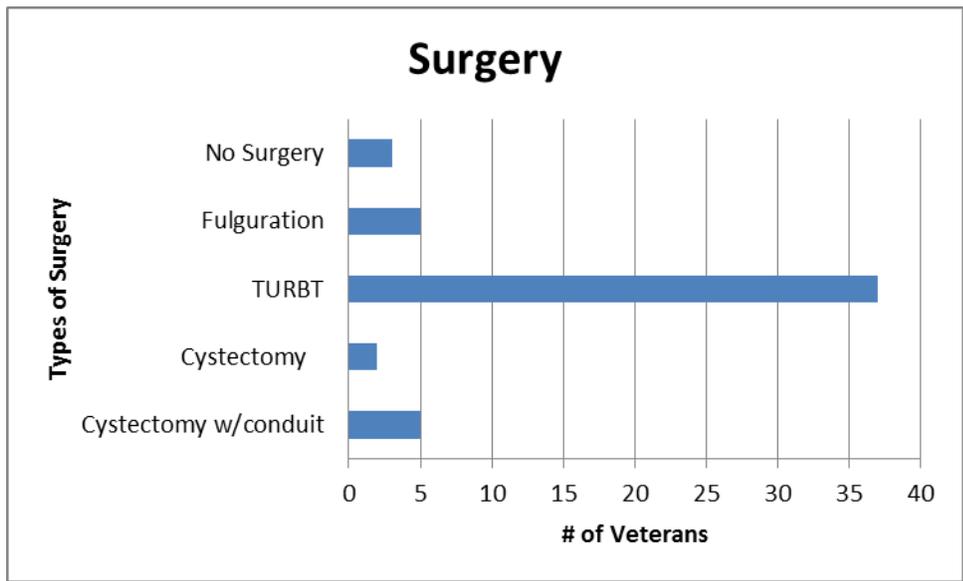
FIRST COURSE OF TREATMENT 2013 Data

Of the 51 Veterans who were diagnosed with bladder cancer in 2013, 34 Veterans (67%) received surgery only, 5 Veterans (9%) received chemotherapy and surgery, 1 Veteran (2%) received chemotherapy and radiation, 7 Veterans (14%) received surgery and biotherapy, 2 Veterans (2%) received surgery followed by chemotherapy, 1 Veterans (2%) received chemotherapy, radiation, and surgery, 1 Veteran (2%) received supportive care only, and there is no treatment documentation for 1 Veteran (2%).



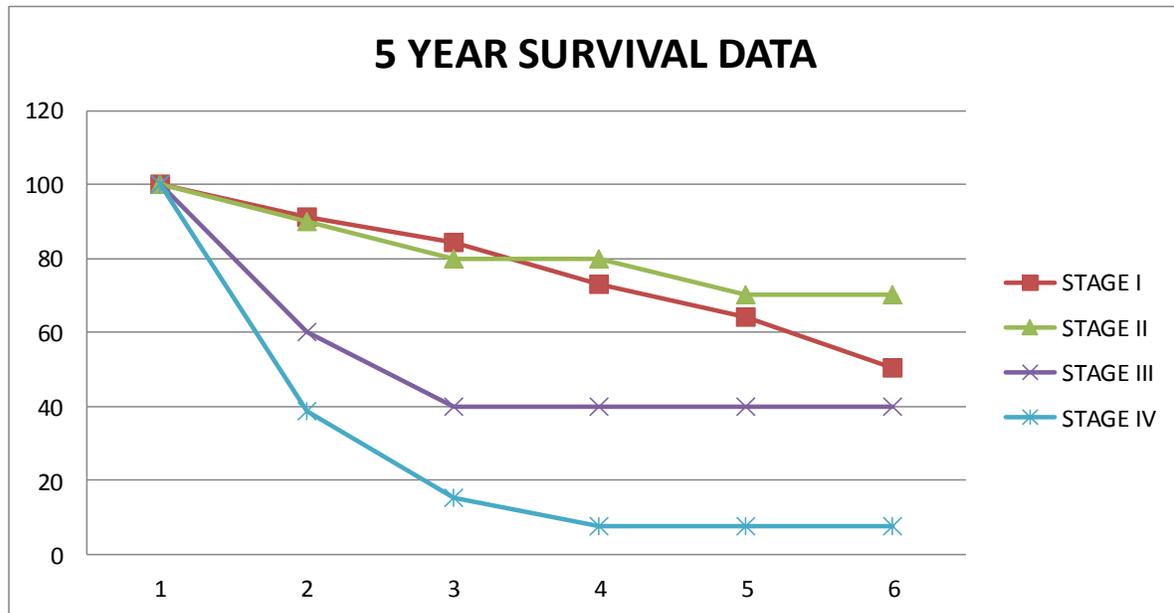
TYPES OF SURGERY

Of the 51 Veterans who received treatment at VACT in 2013, 5 Veterans (10%) had local tumor excision via electro-cautery/fulguration, 37 Veterans (71%) had Transurethral Resection of Bladder Tumor (TURBT) and 2 Veterans (4%) had Radical Cystectomy, 5 Veterans (10%) had a radical cystectomy with ileal conduit and 3 Veterans (5%) who had no surgery.



FIVE YEAR SURVIVAL STUDY BLADDER CANCER

64 cases out of 358 cases did not meet criteria for inclusion in the chart due to a stage of 0 or unknown stage group.



YEAR	STAGE I	# Veterans	STAGE II	# Veterans	STAGE III	# Veterans	STAGE IV	# Veterans
0	100	45	100	10	100	5	100	13
1	91.1	41	90	9	60	3	38.5	5
2	84.4	38	80	8	40	2	15.4	2
3	73.2	32	80	8	40	2	7.7	1
4	64	28	70	7	40	2	7.7	1
5	50.3	22	70	7	40	2	7.7	1

DISCUSSION

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Bladder cancer remains a morbid condition with a poor prognosis for higher stage disease and relatively stable incidence of cases over the last five years. It is one of the most common cancers diagnosed at VACT, but fortunately, the majority of patients are diagnosed at early, curable stages. The stage distribution for bladder cancers diagnosed at VACT between 2000 and 2011 is similar to that reported from the State of CT, NCDB, and VA national level. Similarly, the 5-year survival data is consistent with the published literature.

The mainstay of treatment remains local endoscopic resection and fulguration for low stage disease and more aggressive treatment with neoadjuvant chemotherapy followed by cystectomy for muscle invasive disease. Chemoradiation has a role for patients who are not fit for cystectomy. Patients with metastatic disease receive palliative chemotherapy (usually platinum/gemcitabine) with modest prolongation of survival. One of the most exciting developments in bladder cancer is the activity of anti-PD-L1 (programmed death-ligand 1) in this disease. In a seminal paper in Nature this year (27 November 2014), an international group of investigators (which included two researchers from the Yale Cancer Center) reported on the activity of MPDL3280A (an anti-PD-L1 antibody) in 67 patients with this disease. Response rates correlated with the PD-L1 immunohistochemistry (IHC) staining of tumor infiltrating immune cells and ranged from 50% (IHC 3, n=10) to 11% (IHC 0/1). Responses were durable and the median duration of response has not been reached.

Glossary & Acknowledgements

ACCESSIONED: The order in which patients are entered into the tumor registry for a given year. Each patient has one unique accession number.

ACoS: Abbreviation for the American College of Surgeons

AJCC: Abbreviation for American Joint Committee on Cancer, responsible for the TNM cancer staging.

AMERICAN COLLEGE OF SURGEONS: The administrative body responsible for the establishment of guidelines for approved cancer programs.

ANALYTIC: Cases which are first diagnosed and/or received all or part of the first course of therapy at VA Connecticut Healthcare after January 1, 2000, and are eligible for inclusion in treatment and statistical analysis of the database.

FIRST COURSE OF TREATMENT: The initial tumor directed treatment or series of treatments, usually initiated within four months of diagnosis.

NATIONAL CANCER DATABASE: Data collected from hospital cancer registries across the country by the American College of Surgeons Commission on Cancer, which is used to show trends in cancer diagnosis, treatment and outcome.

NCDB: Abbreviation for National Cancer Database.

NON-ANALYTIC: Cases which are first seen at VA Connecticut after a full course of therapy has been completed elsewhere and are now referred for recurrence or subsequent therapy. These cases are not generally included in treatment and survival statistics, but may be included in administrative reports.

PRIMARY SITE: The anatomical location within the human body considered the point of origin for the primary malignancy.

Acknowledgements:

The Connecticut Tumor Registry, 2011

The Cancer Program at VA Connecticut Healthcare is accredited by the American College of Surgeons Commission on Cancer as a Teaching Hospital Cancer Program.