Medical Director’s Letter

Abraham Lincoln said, “The best thing about the future is that it comes one day at a time.” One way to interpret this is that today is yesterday’s future, so in a sense, the future is here. For those with cancer, the future is here. Here in 2012, and here at Baylor Charles A. Sammons Cancer Center. The number of cancer survivors in the U.S. grows annually and through discovery of the pathways that distinguish cancer cells from their normal counterparts, new and more specific treatments are becoming available.

In 2012 we opened the new Baylor T. Boone Pickens Cancer Hospital, adding an inpatient facility designed for the needs of the cancer patient, to complement Baylor Charles A. Sammons Cancer Center’s outpatient facilities that opened in 2011. We not only opened physical doors, but we also opened a door to view the journey of three patients through their cancer care with the acclaimed documentary, Dallas Hope.

To keep the flame of the future burning brightly, we welcomed two of our graduating fellows, Drs. Micah Burch and Carolina Escobar to our medical staff. Dr. James Fleshman joined us after a distinguished tenure at Washington University in St. Louis to become Chief of Surgery at Baylor University Medical Center. We also welcomed JaNeene Jones, RN, FACHE, who took over as Vice President for Oncology and COO of Baylor T. Boone Pickens Cancer Hospital.

This year, we launched Baylor Charles A. Sammons Cancer Center network. The cancer programs at six additional Baylor hospitals now carry the Sammons name. Each of these programs has achieved accreditation from the American College of Surgeons’ Commission on Cancer and participates in network research, education and quality initiatives. Our goal is to provide outstanding evidence-based and compassionate cancer care throughout our communities.

We look forward to 2013—we look forward to tomorrow—because although the future is here today, it is also still ahead of us and will continue to bring us hope.

Alan M. Miller, MD, PhD
Chief of Oncology, Baylor Health Care System
Medical Director, Baylor Charles A. Sammons Cancer Center at Dallas
The Future of Cancer Care Begins with Hope

Dallas Hope

If you look up the word “hope” in Webster’s Dictionary, it is described as the emotional state that promotes the belief in a positive outcome related to events and circumstances in one’s life. Television viewers across North Texas had a front-row seat to witness our hope at work in the three-part series premiere of Dallas Hope. This unprecedented documentary, which aired on WFAA Channel 8 in November, highlighted the hope that follows a cancer diagnosis.

The series followed the lives of three cancer patients undergoing treatment at Baylor Charles A. Sammons Cancer Center at Dallas. The stars of Dallas Hope who let us into their lives are Michelle Berndt, a 30-year-old mother of two; Cherysse Daniels, a 25-year-old leukemia survivor; and Bill Bradford, a 78-year-old retired business executive. Their heartfelt journeys and real-life battles with cancer connected viewers with their everyday acts of courage, faith and hope.

To celebrate the premiere of this documentary, a special Hollywood-style red carpet event and screening was held on October 30, 2012, at Baylor T. Boone Pickens Cancer Hospital.
Baylor T. Boone Pickens Cancer Hospital Grand Opening

Baylor T. Boone Pickens Cancer Hospital, the region’s first dedicated cancer hospital, joins Baylor Sammons Cancer Center at Dallas in providing advanced cancer care. The grand opening was held in early November 2012. The new hospital opened in two existing buildings at Baylor Dallas that underwent a $125 million renovation.

“The cancer hospital and cancer center are fully integrated and were built to complement each other,” stated Alan Miller, MD, PhD, chief of oncology for Baylor Health Care System and medical director of Baylor Sammons Cancer Center.

The hospital offers quality care with staff trained in all aspects of cancer treatment, including an oncology evaluation and
treatment center, a blood and marrow transplant unit and a variety of support services.

**Oncology Evaluation and Treatment Center**

Receiving prompt, specialized care for urgent but non-emergency conditions is especially important for people receiving treatment for cancer. At night and on weekends, this often means a trip to the emergency room. But, with patients’ already weakened immune systems from cancer treatment, being exposed to infectious diseases in an emergency room can compromise their condition.

Baylor University Medical Center at Dallas opened the Oncology Evaluation and Treatment Center to provide scheduled urgent, non-emergency medical care for patients currently receiving cancer care at Baylor Dallas. The center offers care designed specifically for cancer patients. Staff are trained and knowledgeable about specific issues, symptoms and side effects related to cancer treatment, including excessive nausea or pain.

The center is open from 4 p.m. to 7 a.m., Monday through Thursday, and from 4 p.m. Friday to 7 a.m. Monday. Appointments are required, which helps reduce waiting times.
Programs of Focus

**JaNeene Jones Named New Vice President of Baylor Health Care System Oncology Services**

In February 2012, JaNeene Jones, RN, FACHE, began her new role as vice president of Baylor Health Care System oncology services, as well as chief operating officer of Baylor T. Boone Pickens Cancer Hospital and Baylor Sammons Cancer Center at Dallas on the Baylor Dallas campus.

Jones began her career at Baylor more than 25 years ago as an administrative fellow and advanced to various leadership roles with Baylor University Medical Center at Dallas and the system. Most recently, she served as BHCS vice president of transplantation services for four years.

**Baylor Health Care System Brands Sammons Cancer Centers Across the Metroplex**

Seven facilities across Baylor Health Care System are now branded with the Baylor Charles A. Sammons Cancer Center name as part of the system’s push to bring patients throughout North Texas the quality clinical care and advanced technology for which Baylor Charles A. Sammons Cancer Center at Dallas is known.
Baylor Health Care System facilities in Fort Worth, Garland, Grapevine, Irving, Plano, and Waxahachie hold certifications from the American College of Surgeons’ Commission on Cancer. This system-wide approach to extend the Sammons Cancer Center name was based on the facilities’ achievement of this certification and to show Baylor’s commitment to cancer care, cancer research and cancer education.

“We are very excited about growing together to bring quality cancer care to the citizens of North Texas and beyond,” said Alan M. Miller, MD, PhD, chief of oncology, Baylor Health Care System and medical director of Baylor Charles A. Sammons Cancer Center.

Like the Baylor Dallas location, these new cancer programs will have patient navigators and genetic counselors available at each location to help patients through their diagnosis, treatment and care. Other benefits of the system-wide approach include better collaboration on cancer research and education and access to clinical trials across the Sammons cancer network, said JaNeene Jones, RN, FACHE, Baylor Health Care System vice president of oncology services and chief operating officer of Baylor Sammons Cancer Center at Dallas and Baylor T. Boone Pickens Cancer Hospital.

In addition to the now seven Sammons Cancer Centers, facilities located in McKinney and Carrollton are expected to join the Sammons cancer network in the future.
Innovative Clinical Trials Center Ribbon Cutting and Support from Swim Across America

Baylor Charles A. Sammons Cancer Center at Dallas held a ribbon cutting for the Innovative Clinical Trials Center (ICTC) on June 8, 2012, in honor of Swim Across America’s (SAA) commitment to raising funds benefiting the ICTC. The ICTC offers patients better access to a wide range of new research and treatment options. The ICTC expands the already extensive program of cancer clinical trials offered at Baylor Sammons Cancer Center.

The ICTC consolidates all oncology phase I clinical trials from Baylor researchers and their academic and clinical research partners in one facility located on the 7th floor of Baylor Sammons Cancer Center. Qualified patients will receive all testing and treatments during trials at the center.

“The ICTC will simplify the process for patients participating in a clinical trial by providing one location for clinical examinations, infusions, imaging studies, sample collection for lab work, and follow up,” said Carlos Becerra, MD, medical director of the ICTC and an oncologist on the medical staff at Baylor University Medical Center at Dallas. “The ICTC is dedicated to providing access to treatments only available in a few centers around the world, including immunotherapeutic options such as cancer vaccines from Baylor Institute for Immunology Research and pharmaceutical agents selected for specific molecular targets.”

Swim Across America (SAA), a national organization that holds dozens of community-oriented open-water swims, is committed to raising $1 million for cancer research, prevention and treatment at Baylor’s ICTC over a four-year period. In June 2012, more than 300 swimmers and volunteers, including JaNeene Jones, RN, FACHE,
vice president of oncology services for Baylor Health Care System, Alan M. Miller, MD, PhD, chief of oncology for Baylor Health Care System and medical director of Baylor Sammons Cancer Center, and Dr. Becerra participated in the fundraising swim. Over the last two years, SAA has raised more than $635,000 that directly benefits the ICTC phase I clinical trials program.

According to Daniel Watters, chairman of the local SAA committee and member of the 1988 Olympic swim team, SAA chose to support the ICTC at Baylor Sammons Cancer Center after an intensive search for the best of the best in terms of cancer research in North Texas. The 2011 open-water swim represented the first year of an initial four-year sponsorship of the ICTC.

“Our goal is to raise in excess of $1 million during those four years,” said Watters. “We hope and anticipate that this commitment will be extended for many years.”

**Baylor Health Care System is a Gold Standard Employer**

Baylor Health Care System received CEO Cancer Gold Standard™ accreditation, recognizing its extraordinary commitment to the health of its employees and their families. The CEO Roundtable on Cancer, a nonprofit organization of cancer-fighting CEOs, created the CEO Cancer Gold Standard in collaboration with the National Cancer Institute, many of its designated cancer centers, and leading health nonprofit organizations and professionals. Today, more than 3 million employees and family members are benefiting from the vision and leadership of employers who have chosen to become Gold Standard accredited.

The CEO Cancer Gold Standard calls for companies to evaluate their health benefits and corporate culture and take extensive, concrete actions in five key areas of health and wellness to fight cancer in the workplace. To earn Gold Standard accreditation, a company must establish programs to reduce cancer risk by prohibiting tobacco use at the workplace, encouraging physical activity, promoting healthy nutrition, detecting cancer at its earliest stages when outcomes may be more favorable, and providing access to quality care, including participation in cancer clinical trials.

**Integrative Medicine: Sticking It to Cancer Treatment Side Effects**

One of the oldest healing practices in the world, acupuncture has long been part of traditional medicine practiced in China and other Asian countries. According to the National Center for Complementary and Alternative Medicine, part of the National Institutes of Health, acupuncture aims to “restore and maintain health through the stimulation of specific points on the body.” Many studies show that acupuncture works by releasing natural chemicals in the body, such as endorphins, to inhibit pain or change the perception of pain.

“Acupuncture involves the stimulation of defined anatomical points on the body using a variety of techniques,” said Carolyn Matthews, MD, medical director of the Integrative Medicine program and gynecologic oncologist on the medical staff at Baylor University Medical Center at Dallas. “The needles used are extraordinarily thin and are stimulated manually, electronically or with heat to achieve the desired effect of pain relief.”

Today, the American Academy of Medical Acupuncture (AAMA) reports that 3,500 physicians and almost 12,000 nonphysicians in the United States are practicing acupuncture. An additional 400 to 500 physicians are being trained annually according to AAMA standards in this therapy.
Crystal Griffith: Moving on with Life

Crystal Griffith was trying to be a supportive friend. She had just graduated from college and was starting a career and her young adult life. A younger friend confided that a suspicious spot was found on her breast as part of her annual gynecologic exam. She asked Griffith to accompany her to the biopsy.

“I was scared for her and I wanted to help,” says Griffith. “But I also was thinking, ‘Here I am older than her and I have never had a yearly exam.’ I got a funny feeling about it, but that feeling turned to fear when I felt a lump myself two weeks later. I would never have had the courage to go in, but seeing my friend go through it, I knew what I had to do. I scheduled an appointment with my doctor right away.”

Thankfully, Griffith’s friend’s biopsy results were benign. However, Griffith was not so lucky. At age 25, she was diagnosed with breast cancer.

“I told my friend she had saved my life,” says Griffith. After surgery, 16 rounds of chemotherapy and 35 rounds of radiation therapy, she is once again moving on with her life. “I had to take a year off of my life to do all this,” she says. “But now I have accepted it and am feeling more confident.”
“Acupuncture is a time-honored treatment for many of the symptoms experienced by cancer patients,” said Dr. Matthews. “The wonderful thing about acupuncture is that it has very few side effects and it won’t interfere or interact with a patient’s medications. Most who try this are open to new approaches or have not had as much relief as they would like with what they have already tried to control treatment side effects. Most acupuncture patients feel quite good at the end of treatment.”

**Combining the Art and Science of Head and Neck Cancer Care**

In the past 20 years, the incidence and death rates from oral and head and neck cancers have been declining in all populations, according to the National Cancer Institute. While these cancers are usually treatable, especially if caught early, therapies can cause lasting side effects including disfigurement, loss of smell or taste and dry mouth. Physicians on the medical staff and clinical professionals at Baylor University Medical Center at Dallas work as a coordinated team to diagnose and develop a treatment plan for each patient diagnosed with an oral or head and neck cancer and help reduce these life-altering side effects.

“Head and neck cancer is a big challenge,” said John C. O’Brien, Jr., MD, a surgeon on the medical staff at Baylor Dallas. “Nowhere else is the art and science of surgery challenged as much as it is in the head and neck area. The preservation of form, function and quality of life is difficult. We prioritize the cancer ablation (removal), preservation of function and cosmetic results—in that order.”

Most often, treatment includes surgery, radiation therapy and/or chemotherapy, all of which can cause long-lasting side effects. While surgery is commonly performed before radiation or chemotherapy, newer types of chemotherapy drugs have been developed that allow certain patients to avoid surgery altogether.

“There have been a lot of clinical trials that have looked at ways to treat patients and avoid performing surgery,” said Lance Oxford, MD, an otolaryngologist on the medical staff at Baylor Dallas. “This is one of the biggest advances in head and neck cancer in 20 years. For example, certain patients can be treated first with chemotherapy and radiation therapy in an effort to keep their vocal chords intact and avoid a laryngectomy or removal of part of or the...
entire larynx, which can affect breathing, swallowing and speaking.”

Any needed reconstruction procedures are discussed during the initial treatment planning process. If possible, these surgeries are performed at the same time. New technology available at Baylor University Medical Center at Dallas enables physicians and reconstructive surgeons on the medical staff to discuss and visualize a treatment plan that is tailored for each patient. This new 3-D technology allows head and neck surgeons to measure the area that needs to be resected. During the same procedure, the plastic surgeons can also perform necessary reconstruction, which provides many patients a better recovery. “Often, the reconstructive surgery can be performed right away so the patient leaves the hospital essentially whole again,” added Jason Potter, MD, a plastic surgeon on the medical staff at Baylor Dallas. “These issues are a significant concern with head, neck and oral cancer patients, and I think we can reassure them that not only are they getting advanced treatment for their cancer, but we are doing everything possible to get their life back to where they were before.”

This type of cancer that affects every part of a patient’s life requires teamwork and expertise. Baylor Charles A. Sammons Cancer Center strives to meet the challenges of patient cases and looks at their individual situations to develop an appropriate treatment plan. Dedicated physicians and medical staff, along with emotional and spiritual support, work in tandem to provide this multidisciplinary approach to advanced cancer care.

**Oncology Outpatient Dental Clinic**

Chemotherapy, radiation treatments and transplants affect many different parts of the body, including the mouth, teeth and gums. The Oncology Outpatient Dental Clinic at Baylor Sammons Cancer Center provides preventive and proactive oral health care before and after cancer treatment or organ transplantation. Organ transplant recipients have a higher risk of oral cancer and should undergo regular screenings to detect cell abnormalities or irregularities.

“It is important to see a dental oncology professional before beginning cancer treatment,” said Jane Cotter, RDH, MS, dental hygienist. “There is much the dental clinic staff can do to prevent significant oral pain
and infection by seeing a patient before, during and after treatment.”

The dental oncology clinic and lab services are designed to reduce the incidence of oral complications associated with such treatments. The dentists and dental hygienists on the medical staff of the Oncology Outpatient Dental Clinic understand the special oral needs of cancer and transplant patients and will coordinate with the patient’s primary physician to take an active stance in preserving their dental health.

In addition to dental oncology services, tobacco cessation counseling is offered to patients, their family members and the public. Ms. Cotter also is a certified tobacco treatment specialist and offers services such as quitting resources, nicotine replacement therapies and prescribed nicotine replacement therapies.

**Hope Lodge**

Patients and their caregivers who travel out of town for treatment will have a place to call home away from home in Dallas. The American Cancer Society announced that a Hope Lodge location will be coming to the area soon, located on the campus of Baylor University Medical Center at Dallas.

Hope Lodge offers cancer patients and their caregivers a free, temporary place to stay when their best hope for effective treatment may be in another city. According to the American Cancer Society, Hope Lodge provides a nurturing, home-like environment where guests can retreat to private rooms or connect with others. Currently, there are 31 Hope Lodge locations throughout the United States.
Maria James: The Biggest Win of Her Life

Maria James coaches girls basketball. She survived cancer twice. After 9 years of being cancer-free, she was treated again at Baylor for a different type of breast cancer. She’s now been cancer-free for more than 3 years. It’s the biggest win of her life.

We’ve been pioneering cancer research and treatments for 35 years and thousands of patients. That adds up to one huge commitment to erase cancer.
Cancer education and support are two essential components in the treatment process. Named in honor of former patient Virginia R. Cvetko, the Cvetko Patient Education and Support Center provides many disease-specific education and support programs to help patients and their caregivers understand and navigate the physical, emotional and spiritual challenges of fighting cancer.

Healing with Support
During the cancer journey, support is important for patients and their caregivers to connect. Baylor Sammons Cancer Center offers many different types of support groups, ranging from educational to disease-specific, through the Virginia R. Cvetko Patient Education Center.

In March 2011, Janie Walker was taken by surprise when she was diagnosed at age 58 with nasopharyngeal cancer, a form of head and neck cancer. While going through 8 weeks of chemotherapy and 35 radiation treatments, Janie’s physicians recommended she join a cancer support group. Below, Janie shares her experience.

Janie Walker, Head and Neck Cancer Survivor
I first heard about the SPOHNC (Support for People with Oral and Head and Neck Cancer) group when I began my chemo and radiation treatments. My doctors strongly urged me to attend, because they were aware of how much I would need the support and help of the friends I would make there. I started attending meetings, and of course, the further I got into this horribly debilitating treatment, the more I found I needed their strength and advice. I quickly made friends with many who were either currently in treatment like myself or who had already weathered the storm and were leading somewhat normal lives again. There is something very special about meeting with people who understand all that you are experiencing. Throat cancer treatment damages one of the most essential areas of the body, since humans use their throats to eat, drink and survive. Therefore, I would say that this group is one of the most necessary support elements available. I can’t say enough about how important it was for me to see these folks in their different stages of recovery. They made me realize there was hope for me to someday recover and showed me that my life could follow their example of restoration. When you are in the midst of the worst part, you can’t imagine that you will ever be able to be normal again. Of course, as we always say in the group, the definition of normal is forever changed, but you adapt to a “new” normal.

I am one who will be eternally grateful for the help and support I received through this support group and for the lifelong friends I’ve made during such a difficult time, when I needed them most.
**Survivors’ Celebrations**

Several annual celebrations to honor cancer survivors of prostate, ovarian, breast, and lung cancers were hosted by the Cvetko Center. Survivors and their guests enjoyed a luncheon, community resources/information and a keynote speaker:

- **Prostate cancer:** Author and prostate cancer survivor Bob Hill presented at this celebration with the topic, “The Club No Man Wants to Join.” Hill is the author of *Dead Men Don’t Have Sex: A Guy’s Guide to Surviving Prostate Cancer*. The book is based on his personal journal, which he began within two hours of diagnosis, and chronicles his entire prostate cancer experience through surgery, recovery and rehabilitation.

- **Ovarian cancer:** “Beyond Survival: How Cancer Can Deepen Our Capacity for Joy, Meaning, and Connection” was presented by Martin Lumpkin, PhD, at this celebration. Dr. Lumpkin is an award-winning psychologist who specializes in helping those who struggle with various stress-related conditions.

- **Breast cancer:** Leslie Mouton, anchor at KSAT 12, the ABC affiliate in San Antonio, Texas, is a breast cancer survivor, and she shared her cancer journey with viewers every step of the way. She made the ultimate statement in support of cancer patients by anchoring one newscast without her wig. Mouton did it to show people the reality of cancer, to inspire other women losing their hair, and hopefully to ease the fear of being bald. At this year’s celebration, Mouton presented “All About Attitude” to survivors.

- **Lung cancer:** Kartik Konduri, MD, an oncologist on the medical staff at Baylor University Medical Center at Dallas, presented at this first-ever lung cancer survivor celebration and luncheon. His topic was “Lung Cancer 2012: Where Are We and Where Do We Go from Here?”

**Healing Arts Performance Series**

Grammy Award–winning harpist Merry Miller was the first musician to kick off the new Healing Arts Performance Series at Baylor University Medical Center at Dallas in September 2012. The Healing Arts Committee seeks to offer Baylor staff,
patients and their families quality performing art as an opportunity to briefly unwind and relax. The free, quarterly events showcase professional artists who have a passion for creating healing sounds and movement.

“If there is ever a time people need the peace and tranquility, joy and pleasure of music and the arts, I think it’s when they are spending time in a medical facility,” said Pam Carnevale, manager of the Virginia R. Cvetko Patient Education and Support Center. “The Healing Arts Performance Series is intended to promote a restful atmosphere and bring comfort to patients and their caregivers.”

Miller, an internationally renowned harpist, has released more than a dozen albums, including the bestselling *Tranquility* and *Serenity*, and she has performed on NBC’s *Today Show*, ABC’s *Good Morning America* and Fox News.

In December, renowned bass-baritone Donnie Ray Albert was the featured performer. As a trained operatic singer from Southern Methodist University, Albert has performed on Broadway and with the Washington National Opera. Just in time for the holidays, Albert’s performance was entitled “Traditions of the Season.”

The main purpose of the Healing Arts Performance Series is to raise awareness of the role of the healing arts in support of modern medicine. Since its inception five years ago, the Healing Environment Fund’s goal is to continue to bring beauty into a sometimes scary setting.

**FitSteps for Life®**

Exercise is beneficial not only for the physical body, but also for the mind and spirit of the cancer patients who participate in the FitSteps for Life® program at Baylor Sammons Cancer Center at Dallas. Research demonstrates that exercise improves cancer survival up to 50 percent. Exercise immediately benefits patients going through the most emotionally, physically and financially challenging times in their lives—so much so that the American Society of Clinical Oncology now recommends that exercise be incorporated into routine cancer treatment. Barbara Haas, MD, professor at the University of Texas at Tyler and Cancer Foundation for Life® board member and research director, collected 5 years of data on FitSteps participants. The data, published in the *Journal of Oncology Practice*, show that within 1 month, patients experience statistically significant improvement in physical health, mental health, vitality, social function, and bodily pain, all of which can be sustained long-term.

At the Baylor Dallas FitSteps program, trainers see patients at all stages of the cancer continuum. “An increasing number of patients are exercising during radiation treatment and chemotherapy as well as before and after bone marrow and stem cell transplants,” said Kathy Kresnik, FitSteps clinical exercise specialist. “The convenient location facilitates patient participation and gives a welcome destination for inpatient members and their spouses or caregivers.”

Members can participate in both exercise classes and an individualized program of aerobic exercise, stretching, muscle strengthening and balance exercises focusing on core strength. The Hank Dickerson Wellness Center located in the Oncology Outpatient Clinic is equipped with treadmills and elliptical machines for cardiovascular activity, stability balls to improve balance and core strength and resistance bands and light dumbbells for muscle strengthening and toning. Basic
movements are taught by a clinical exercise specialist and can be easily continued at home with minimum equipment, while still providing maximum benefits. Since relocating to the new outpatient cancer center in 2011, there have been more than 4,000 visits by patients to the FitSteps® program.

Any cancer patient or survivor may participate free of charge. All members must have a physician referral to get started; they are then scheduled for a one-on-one evaluation and personal training session to design a fitness routine to meet their current needs. Staff trained in exercise science supervise members and continue to work with them, adjusting their exercise routine as their abilities change.

**Barrett Lectureship**

The Charlotte Barrett Lectureship was given by Deforia Lane, PhD, MT-BC, in the Hunt Auditorium at Baylor Sammons Cancer Center at Dallas on December 5, 2012. Dr. Lane is the resident director of music therapy at University Hospitals Seidman Cancer Center in Cleveland, Ohio. She has designed and implemented music therapy programs for diverse patient populations, from the mentally handicapped to those with cancer.

Dr. Lane distinguished herself in her ability to empathize with seriously ill patients because of her personal struggle with cancer.

Her work has been recognized in national publications such as *Reader’s Digest*, as well as other forums, including National Public Radio, CNN, CBS *This Morning* and Wall Street Journal TV. Dr. Lane’s lecture, “Music Therapy and Medicine: A Dynamic Partnership” explained how music therapy is not just a new-age treatment, but has its roots in ancient cultures that incorporated music into healing rituals.

The annual Charlotte Johnson Barrett Lectureship was established to address psychosocial issues and concerns of cancer survivors and their families. Charlotte Barrett was a cancer patient who helped establish the first patient support group at Baylor Sammons Cancer Center at Dallas. After her death in 1982, her family and friends generously established an endowment to support annual programs and seminars relating to cancer patient education and support.
In Memoriam
Chef Ramah “Katie” Bickerstaff, our friend and coworker, passed away on June 8, 2012. She began her career with Baylor in 2007 as executive chef at Baylor Waxahachie. Katie most recently served as the executive chef of Café Charles at Baylor Sammons Cancer Center at Dallas.

Katie was a beloved leader and teacher. Her passion for cooking was evident to all who met her. She loved to conduct cooking demonstration classes for patients at the Diabetes Health and Wellness Institute and at the Virginia R. Cvetko Patient Education and Support Center. While leading her team at Café Charles, she developed a healthy, inviting menu, with fish taco Fridays as one of her signature specials. Katie was truly caring and a thoughtful mentor to her team.

Blood and Marrow Transplant Program: How to Save a Life
In late 2007, Candice Stinnett was 21, a mother to a young son, and had recently begun a job she loved as an emergency dispatcher. When she felt a lump on the side of her neck that didn’t hurt but wouldn’t go away, she didn’t think much of it. When she did get it examined, doctors initially thought it was an infected lymph node and gave her antibiotics. However, when January 2008 rolled around and nothing changed, they ordered a biopsy. The result: non-Hodgkin’s lymphoma.

“Honestly, when they said that, I didn’t know what it was,” she said. “I didn’t know it was cancer. I didn’t want it to be anything serious, much less cancer. I went home and looked it up and just could not believe this was happening.”

Unfortunately, it was happening. Stinnett was immediately fitted for a port to deliver her chemotherapy medications. She received six rounds of chemotherapy treatments, once every 3 weeks. In June 2008, scans revealed the cancer was gone.

But by January of the next year, it had returned. This time, doctors recommended a peripheral blood stem cell transplant to

happily eradicate the cancer cells in her system. “I didn’t understand what a stem cell transplant was,” she said. “I was scared and thought it was something involving surgery. My physician explained it all so well to me. He described the cancer like a fire pit. The chemo was water putting the fire out, but there could still be some embers smoldering. You don’t just want to sprinkle a little water on it. You want to put all the fire out. That is what the transplant would do. It would give me new cells to be healthy.”

Although Stinnett has three sisters, none of them was an appropriate match for the peripheral blood stem cell transplant. A possible donor was found through Be the Match® Registry but was only a 70% match and lived out of the country. Her next best option was an autologous transplant, in which Stinnett’s own peripheral blood stem cells are collected, cleaned, and then reintroduced into her system. After more chemotherapy to shrink existing cancer cells and medication to boost production of existing healthy cells, the transplant took place in June 2009.

During pretransplant procedures and after the transplant itself, Stinnett and her
husband, John, stayed at Baylor University Medical Center at Dallas’ Twice Blessed House, an affordable housing option for transplant patients and their family members who live at least 50 miles away. Because she had a high risk for infection, family members and church friends helped care for their son. Just 6 weeks after the procedure, Stinnett returned to work as a dispatcher.

Although recovering at home and back to work, Stinnett still felt tired all the time. She chalked that up to a stressful job and an active young son. Unfortunately, at her 1-year checkup in July 2010, the non-Hodgkin’s lymphoma reared its ugly head again. “I was incredibly devastated when I was told the cancer was back again,” she said. “When I wasn’t sleeping, I was planning my own funeral. A few weeks later, I learned a donor was found and matched me almost perfectly. I was finally able to smile again, and my future wasn’t a blur anymore. Someone signed up to save my life!”

The procedure to test and prepare the donor took approximately 6 weeks. During that time, Stinnett was given medication and more chemotherapy to keep her disease as small as possible. On October 7, 2010, she received her donor’s stem cells and was able to return home on October 23. This time, she said, after initially not feeling great, she started to feel better and stronger day by day. “Once I started to feel better and got home, I didn’t want the focus to be on cancer anymore,” she said. “I just wanted to be there for my family and live a normal life.”
Leading up to her peripheral blood stem cell transplant, Stinnett said she explained to her son, Jonathan, how the donor’s blood would help her get healthy. While the only information they had about the donor was that he was a man in his early 30s from the United States, Jonathan decided to name him “Brighton.” “He told me he picked that name because he is bright like the sun and shines on our day for me,” said Stinnett. “Thanks to this donor, I have a different outlook on life. I don’t let little things bother me, and we dance every single day. I want to experience life with the windblown hair and springboard beneath my feet.”

In December 2010, 14 months after Stinnett’s transplant, she received a phone call that her donor had released all of his information for the recipient. “After staring at the phone for about 15 minutes trying to think of something to say, I just went ahead and dialed his number,” she said. “He answered and I said, ‘Hi, this is Candice. You saved my life last year.’ He immediately knew who I was, laughed, and we chatted for 45 minutes like we were lifelong friends. His name is Jared and he lives in California and is married with two girls and a boy on the way. The invitation to go visit and stay with them is always open.”

Young Adult Cancer Survivors Dine & Dash
In an effort to better meet the needs of young adult cancer survivors, the Young Adult Cancer Survivors’ Coalition was formed in 2012 through the Virginia R. Cvetko Patient Education Center. Young adults between the ages of 15 and 40 years have had no improvement in survival rates in two decades. As a result, the National Cancer Institute led a national effort to increase support for this population.

Between 2005 and 2010, 2,057 young adults with cancer were treated throughout Baylor Health Care System, according to cancer registry data. This number makes Baylor a leading health care provider for this age group. The mission of the coalition is to improve the quality of life for young adults with cancer. This goal is being accomplished through education, research and psychosocial support.

A special highlight of the coalition is Dine & Dash, a bimonthly support meeting offered for young adult survivors and caregivers. Dine & Dash was designed to move away from the typical support group setting and cater to the interests of young adults. Past activities have included speed networking and a poetry jam, held at various locations throughout Dallas.

“The immediate bonds we all share as young adult cancer survivors bring me a great amount of peace and continue to help in my emotional healing,” said Candice Stinnett, a survivor of non-Hodgkin’s lymphoma. “For a long time I would receive treatment alongside older patients and felt alone. At Dine & Dash, we all have had cancer and are all of similar ages. We know each other's struggles and stories, leaving me feeling truly connected to others during my cancer journey.”

Hematology Patient Advocate Provided by the Leukemia and Lymphoma Society®
To better serve hematology patients in North Texas, the Leukemia and Lymphoma Society® applied for and received a grant from Baylor Charles A. Sammons Cancer Center to hire an in-house hematologist patient advocate. This advocate will better serve hematology patients and their families by providing on-site service. Melissa Garner, LPC, MPS-ATR, started in this position in October 2012 and offices in the Cvetko Center, on the second floor of the cancer center. Garner is working with Cvetko Center staff to provide a comprehensive continuum of care, helping patients with access to the Leukemia and Lymphoma Society’s community resources, blood cancer support groups, patient educational programs, and continuing education opportunities applicable to hematology for clinical staff. Garner will also be visiting Baylor Health Care System facilities around the Metroplex.

Cancer Genetics Program
One of the most significant breakthroughs in cancer research is the ability to identify genes that may contribute to the development of certain types of cancer. Baylor Sammons Cancer Center at Dallas offers the Cancer Genetics Program to help determine if an individual is at risk for one of the genetic mutations that can lead to cancer.

In 2012, the genetic services at Baylor Dallas and across the Baylor Health Care System expanded significantly. Genetic counseling services are now provided by two board-certified genetic counselors who work closely with physicians on the
medical staff from a variety of medical disciplines. More than 500 new patients were seen for genetic counseling compared with 335 new patients in 2011.

Genetic services, which were initially limited to individuals at risk of hereditary forms of breast cancer, have been expanded to include individuals at risk of any benign or malignant tumor. More than 75 patients were seen for a predisposition to a nonbreast malignancy or tumor, including those at risk to develop colon cancer, uterine cancer, ovarian cancer, thyroid cancer, kidney cancer, melanoma, and other predispositions.

Counseling services for oncology-related indications are provided at Baylor Dallas, Baylor Regional Medical Center at Plano and Baylor All Saints Medical Center at Fort Worth. Recently, genetic counseling services were expanded to include counseling for any adult genetic condition. This expansion includes a cardiovascular genetics clinic at THE HEART HOSPITAL Baylor Plano’s Center for Advanced Cardiovascular Care, which has already seen several families for inherited cardiovascular diseases since its inception in October 2012.

**Community Events/Outreach**

Baylor Sammons Cancer Center at Dallas hosts several cancer awareness events and screenings and participates in many health fairs throughout the community. This year, 45 community education/outreach events were held throughout Dallas and surrounding areas that were attended by a total of 2,469 participants. The following highlighted events are just a sample of the outreach activities conducted in 2012.

**Free Community Screenings**

- Baylor Sammons Cancer Center hosted a head and neck cancer screening on April 28 in collaboration with the Baylor College of Dentistry. Of the 100 patients screened, 23 received abnormal results and were encouraged to follow up with their primary care physician.

- Every month, self-referral skin cancer screenings are offered in the Oncology Outpatient Clinic at Baylor Sammons Cancer Center at Dallas. In 2012, a total of 240 patients were screened. Out of this total number, 104 received abnormal results and were encouraged to seek follow-up care with their primary care physician.
Community Outreach Events

• The Mary Kay Expo was held during July and August 2012. The W. H. & Peggy Smith Baylor Sammons Breast Center at Dallas provided breast cancer and gynecological cancer education materials to several hundred Mary Kay sales professionals at the expo, held at the Dallas Convention Center.

• In honor of National Blood Cancer Awareness Month, Baylor Sammons Cancer Center at Dallas participated in the Light It Up Red for Lymphoma national campaign. Started by the Lymphoma Research Foundation, the cancer center glowed red during the weekend of September 21 to 23 to shine a light on blood cancer awareness and support those battling this disease.

• Ovarian and breast cancer survivors along with supporters grabbed their walking shoes for Sole Sisters™ on October 6. This annual event promotes good health/fitness practices and early detection of breast and ovarian cancers. A half-mile torch relay walk inside Baylor Tom Landry Fitness Center Park honoring survivors kicked off in the morning. Afterward, Shannon Miller, Olympic gold medalist and ovarian cancer survivor, served as keynote speaker in a special program held in the Tom Hunt Auditorium at Baylor Sammons Cancer Center at Dallas. Miller shared her experiences as a cancer survivor along with her time spent as a member of the “Magnificent Seven” U.S. women’s gymnastics team, who took home the gold medal at the 1996 summer Olympic games. Event participants enjoyed door prizes, a complimentary lunch provided by Corner Bakery Café, and information tables with health/fitness, nutrition and cancer education materials.

• Saks Fifth Avenue Galleria Dallas and Baylor Sammons Cancer Center put out a call for the most sinful fashion purchases hiding in the back of closets through the Pink Passion®: Closet Confessions contest. Participants had to pin a picture of their fashion crime on Pinterest for a chance to win a shoe shopping spree worth $750 courtesy of Saks. Along with their “closet confession,” contestants also shared their reason for supporting Breast Cancer Awareness Month. The winner of the contest was chosen via in-store voting during the Saks Fifth Avenue Key to the
Cure Fashion Show on October 20, featuring breast and ovarian cancer survivors wearing the latest trends of the season.

- In collaboration with TNT: Tobacco-free North Texas, the American Cancer Society’s Great American Smoke Out™ was held on November 15 in Truett Hospital, located on the campus of Baylor University Medical Center at Dallas. This year’s focus was on the financial toll tobacco use can have on a person’s physical health, medical insurance and environment. The Great American Smoke Out is a national campaign to encourage smokers to quit for one day with the hope that they will remain tobacco-free for life.
The Future of Cancer Care is Here | Baylor Charles A. Sammons Cancer Center at Dallas

Cancer Registry

Summary of 2011
Cancer Registry Data

This report includes the tumor registry data on patients who were first diagnosed or initially treated at Baylor University Medical Center in the year 2011. These are called analytical cases, and in 2011 there were 2911 cases (in 2010 there were 2910 cases). We care for 10% of the cases in our region of Texas Public Health Region 3 (19 counties, 175 facilities) and slightly less than 3% of the cases in Texas. These numbers are stable since 2009.

Several charts are provided comparing our rank of case volume to National Cancer Data Base cancer centers in the U.S. and to Texas hospitals; comparing case numbers by major categories in 2010 and 2011; and finally, looking at 2011 Baylor Sammons cases as a percentage of Region 3 cases.

To summarize, our total case volume was unchanged between the two analytical years 2010 and 2011. There were substantial increases in Gyn and GU case volumes, compared to decreases in GI and lung. Despite these slight changes, our cases as a percentage of Region 3 remain fairly consistent from as low as 5% to as high as 38%.

Department Update

In 2012, the Baylor Dallas Cancer Registry grew with the addition of three registrars. New processes were added to the program, as well as new information technologies.

The registry developed a remote registrar program, recruiting three certified tumor registrars who live outside the Dallas–Fort Worth area: Susanna Arias, CTR, from Fort Lauderdale, Florida; Bonnie Stewart, CTR, from Spokane, Washington; and Briana McCants, CTR, from Bessmer, Alabama. The addition of these experienced registrars brings the cancer registry staff to

(Continued on page 28)
### Baylor University Medical Center Dallas Analytic Cases Diagnosed 2011

<table>
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<tr>
<th>Primary Site</th>
<th>Total Analytic Cases</th>
<th>Gender</th>
<th>General Stage</th>
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<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In Situ</td>
<td>Localized</td>
</tr>
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<td></td>
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<td>Distant</td>
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Benign includes: Gastrointestinal stromal tumors, benign meningiomas, benign brain, and other CNS benign.
Other/Ill-Defined includes: ill-defined sites and hematopoietic diseases not included in the leukemia/lymphoma/myeloma category.
<table>
<thead>
<tr>
<th>Primary Site</th>
<th>Total Analytic Cases</th>
<th>Gender</th>
<th>In Situ</th>
<th>Localized</th>
<th>General Stage</th>
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<td>7</td>
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<td>3 5 0 0 4</td>
</tr>
</tbody>
</table>
(Continued from page 25) a total of seven full-time certified tumor registrars, including the cancer registry manager and supervisor.

In 2012, the ePath® application of Artificial Intelligence in Medicine was approved for installation. The application will save each cancer registrar time due to the automation of casefinding review of 100% of pathology reports. This automation will “read” each pathology report and choose only those cases applicable to the cancer registry. Upon electronic review by a registrar, each case that requires abstracting will be automatically downloaded into the suspense of the database for abstracting. This will not only save time, but also increase efficiency in the cancer registry.

The staff attends monthly webinars, which include presentations from the North American Association of Central Cancer Registries. All Registry staff attended the Texas Tumor Registrars Association (TxTRA) 40th Annual Educational Conference in Hurst, Texas, as well as the Baylor-sponsored annual Cancer Registry symposium The Value of Quality Data, which featured presentations on GI cancers.

### 2011 Top 12 Sites

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<th>BUMC</th>
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</tr>
<tr>
<td>Colorectal</td>
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<tr>
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</tr>
<tr>
<td>Lung</td>
<td>Colorectal</td>
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<tr>
<td>Uterus</td>
<td>Melanoma</td>
<td>Melanoma</td>
</tr>
<tr>
<td>Brain and Other CNS</td>
<td>Bladder</td>
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Invasive Bladder Cancer: The Baylor Experience
By Laith I. Abushahin, MD, Thomas E. Hutson, DO, and Winston S. Webster, MD

Bladder cancer is the fourth most common malignancy diagnosed in men in the United States, with an estimated 73,510 new cases and 14,880 deaths in 2012. More than 90% of these new cases in the U.S. will be urothelial or transitional cell carcinomas. Bladder cancer is rarely diagnosed before the age of 40, and the median age of diagnosis is 65, which can alter treatment plans due to the presence of comorbidities. Patients with bladder cancer typically present with painless hematuria; however, the initial presentation can be irritative voiding symptoms such as increased frequency, urgency, and dysuria. In men over the age of 40, the presence of otherwise unexplained hematuria indicates urothelial cancer until proven otherwise by a urologic evaluation of the entire urinary tract. Cystoscopy is the gold standard for the initial evaluation of patients with potential bladder cancer. Patients with visible tumors have the tumors either biopsied or resected to determine the histology, as well as the depth of invasion. Most invasive bladder cancers are high-grade tumors. These tumors originate in the bladder mucosa, progressively invade the lamina propria, and then move into the muscularis propria, perivesical fat, and contiguous pelvic structures, with increasing incidence of lymph node involvement with progression. The depth of invasion by the primary tumor is the most important prognostic variable for progression and overall survival for localized disease, especially with degree of muscle invasion. Stage II is the first stage the tumor invades the muscle. In stage III, the tumor extends just beyond the muscle layer and can extend into the prostatic stroma, uterus, and/or vagina. In stage IV, the tumor invades even further, into the pelvic or abdominal wall. Lymph node involvement has been reported as an important prognostic marker as well in several studies. The TNM staging system now classifies any lymph node involvement, as well as metastatic disease, as stage IV.

Historically, the clinical spectrum of bladder carcinoma was divided into three categories that differ in prognosis, management, and therapeutic intentions: nonmuscle-invasive disease, muscle-invasive disease, and metastatic cancer. Nonmuscle invasive tumors comprise approximately 65% to 70% of new bladder cancer cases. This category of bladder cancer includes Ta (papillary), T1 (submucosal invasive), and Tis (carcinoma in situ). Treatment is directed at reducing recurrences and preventing progression. The initial intervention generally is a complete transurethral resection of all visible bladder tumors (TURBT). This is often followed by adjuvant intravesical therapy. Muscle-invasive tumors represent around 30% of cases on presentation. This group encompasses several different entities including stage II (T2), stage III (T3, T4a), and stage IV (T4b or lymph node–positive disease) and is an area of great interest in bladder cancer research. The main reason this group is of such interest is to determine if bladder preservation is possible without compromising survival. Radical cystectomy is the standard treatment of choice in the U.S. for this stage, although bladder-sparing approaches have gained favor in recent years. Another issue is to determine if the lesion can be managed locally or if the patient is at high risk for distant spread requiring systemic therapy. Lastly, the third group encompasses patients with distant metastatic disease. In these cases, therapy aims to prolong survival and improve quality of life. Advances in the use of cisplatin-based combination chemotherapy have led to improved survival. Despite this progress, metastatic disease is associated with a limited life expectancy, and cures are rare.

Locally advanced and metastatic disease have been the primary focus of research due to the high mortality and morbidity of urothelial cancer of the bladder (UCB). Despite adequate local control after cystectomy, the overall survival (OS) for muscle-invasive UCB is suboptimal; 5-year OS rates are 52% to 77% for pathologic T2 disease; 40% to 64% for T3 disease; and 26% to 44% for T4 or node-positive disease. Most patients who succumb to bladder cancer ultimately die due to distant disease rather than locoregional recurrent disease. Historically, the recommended treatment for muscle-invasive disease (≥T2) was radical cystectomy with lymph node dissection. Based on successes seen in the treatment of other epithelial neoplasms, chemotherapy was combined with surgery to improve the likelihood of cure. The use of neoadjuvant chemotherapy offers potential advantages over adjuvant therapy, including early
treatment of systemic micrometastases, potential downstaging of primary and regional disease, and an in vivo assessment of chemosensitivity. Giving chemotherapy in the neoadjuvant setting also avoids potential delay in systemic treatment due to postoperative complications, as 58% of patients may have postsurgical complications after radical cystectomy.6 Several studies support the role of neoadjuvant chemotherapy for T2 and T3 UCB lesions. Grossman et al reported that patients who received methotrexate, vinblastine, Adriamycin (doxorubicin), and cisplatin (MVAC) followed by radical cystectomy showed a 21-month OS advantage over cystectomy alone.6 Two Nordic trials found an OS benefit of neoadjuvant therapy when combined with radical cystectomy in patients with pT3-T4 disease when compared to cystectomy alone (5-yr OS 56% vs 48%; P = 0.049).10 A clear OS benefit for neoadjuvant therapy (cisplatin, methotrexate, vinblastine; CMV) was found for patients with cT2 grade 3-T4N0 muscle-invasive UCB compared to cystectomy alone at the 10-year mark (36% vs 30%; P < 0.05) in the International Collaboration of Trialists trial.11 These results, as well as the results of many other trials, indicate that neoadjuvant chemotherapy improves outcomes for muscle-invasive bladder cancer. Postoperative adjuvant chemotherapy is another systemic treatment option for patients with muscle-invasive bladder cancer. Use of adjuvant chemotherapy allows for immediate surgical intervention, providing debulking and relief of local symptoms. Another advantage of adjuvant chemotherapy is that its use can be based on complete pathologic staging of the tumor, which more accurately assesses a patient’s risk, as clinical staging is often inaccurate. Data regarding adjuvant chemotherapy are conflicting, as no randomized trials of sufficient sample size have shown a survival benefit.12 Many of the trials showing a survival benefit were not randomized, which raises the question of selection bias. Two trials showed survival advantage from therapy with cyclophosphamide, Adriamycin, and cisplatin (CAP), MVAC, or methotrexate, vinblastine, epirubicin, and cisplatin (MVEC).13,14 In contrast, a randomized phase III study with 194 patients reported no difference in OS or disease-free survival15,16; however, the trial closed early due to poor accrual, enrolling only 32% of the target sample size. Nevertheless, the results of these and other current trials suggest that adjuvant chemotherapy may delay recurrence and thus may justify the administration of chemotherapy for patients at high risk of relapse.

Bladder preservation may be accomplished with muscle-invasive UCB, in appropriately selected patients, without compromising outcomes using a trimodality approach. This approach is characterized by maximal transurethral resection (TUR) followed by concurrent chemotherapy and radiation therapy. In appropriately selected patients, bladder preservation with TUR, chemotherapy, and radiation is feasible and produces high rates of complete response with acceptable disease control and OS, all while preserving the bladder. The patients who are candidates for this trimodality therapy have T2-4a bladder cancer with clinically node-negative disease. The primary tumors must be able to undergo complete or near-complete TUR. It is important that these patients have adequate renal function with no hydronephrosis so cisplatin can be administered.17 Most of the studies involving this trimodality therapy use cisplatin-based chemotherapy, but newer agents are being evaluated.16 Thus, even though these studies have promising results, there is still much to be learned on the best approach to treat muscle-invasive UCB.

Finally, metastatic bladder cancer is incurable and requires systemic therapy. Currently the first-line therapy is a combination of cisplatin and gemcitabine or a multidrug combination regimen including cisplatin, such as MVAC chemotherapy. Regimens containing taxanes are being explored for use in front-line therapy. There is no standard second-line therapy for patients with metastatic bladder cancer. Due to this lack of available standard therapies, patients are encouraged to enroll in clinical trials. Otherwise, if a patient decides not to pursue a clinical trial, the available options for patients with metastatic disease depend on what was used in first-line therapy and include fluorouracil, cisplatin, gemcitabine, carboplatin, docetaxel, doxorubicin, ifosfamide, paclitaxel, methotrexate, pemetrexed, and vinblastine.18-26

Methods
Baylor Charles A. Sammons Cancer Center at Dallas is a large tertiary referral center. We identified cases of muscle-invasive, locally advanced UCB treated at Baylor University Medical Center at Dallas
The Future of Cancer Care is Here

| Baylor Charles A. Sammons Cancer Center at Dallas |

Treatment. Figure 1 summarizes the basic treatments received by the cohort. Overall, among patients with stage II disease, two patients (11%) were treated with TURBT: one with TURBT alone secondary to multiple medical comorbidities and another who underwent TURBT followed by Bacillus Calmette-Guerin immunotherapy, a treatment placed into the bladder. One patient (5%) was initially treated with a bladder-preserving technique but had a disease recurrence and required delayed-salvage cystectomy after an 11-month disease-free period, while another (5%) had rapid progression on neoadjuvant chemotherapy and did not have surgery. The remaining 15 patients (79%) underwent cystectomy: nine patients (47%) had cystectomy alone, while six (32%) had chemotherapy with surgery. In this group with surgery and chemotherapy, five patients had neoadjuvant chemotherapy prior to surgery, and one patient (5%) had adjuvant chemotherapy following surgery. In the cases where chemotherapy was used, gemcitabine and carboplatin was utilized in 38%, carboplatin and paclitaxel in 31%, gemcitabine and cisplatin in 15% of the cases, and a combination of both MVAC and gemcitabine, carboplatin, and paclitaxel was used in 7%.

In patients with stage III bladder cancer, two patients (10%) had TURBT alone, while 18 patients (90%) had cystectomies. Patients treated with TURBT did not undergo cystectomy due to the presence of comorbidities prohibiting surgery and chemotherapy. Of those patients who underwent cystectomy, only five patients (25%) had cystectomy alone as their modality of treatment, while the rest of the patients (13) underwent some form of chemotherapy. Of these patients, four (20%) were given neoadjuvant chemotherapy prior to surgery compared to eight patients (40%) who received adjuvant chemotherapy and one patient (5%) who had both neoadjuvant and adjuvant chemotherapies. In the cases where chemotherapy was used, gemcitabine and carboplatin was utilized in 38%, carboplatin and paclitaxel in 31%, gemcitabine and cisplatin in 15% of the cases, and a combination of both MVAC and gemcitabine, carboplatin, and paclitaxel was used in 7%.

Among regional stage IV patients, all 16 patients had some form of cystectomy and chemotherapy. Of these patients, 50% had surgery up front followed by adjuvant chemotherapy; 37.5% had neoadjuvant chemotherapy followed by surgery; and...
12.5% had both neoadjuvant and adjuvant chemotherapies. The chemotherapy choice was MVAC in 37.5% of the cases, gemcitabine and carboplatin in 31%, gemcitabine and cisplatin in 19%, and other chemotherapies in 11% of the cases.

When the results of our study were compared with those of the National Cancer Data Base (NCDB), we found that at all stages of muscle-invasive bladder cancer (stages II-IV), the patients at BUMC received chemotherapy along with surgery more often than the national average (Figure 2). In both cases, the percentage of patients getting surgery combined with chemotherapy increased with stage, but this increase was much more rapid at BUMC. At BUMC, 42%, 68%, and 100% of the bladder cancer patients at stages II, III, and IV, respectively, received surgery and chemotherapy. This is in comparison to 18%, 27%, and 49% of the bladder cancer patients at stages II, III, and IV, respectively, who received surgery and chemotherapy in the NCDB. The averages in NCDB were 54.7%, 45.8%, and 22.7%, respectively, for stages II, III, and IV bladder cancer. Again, these better numbers may be related to more aggressive therapies to treat bladder cancer.

**Survival.** For our cohort of locally advanced, muscle-invasive bladder cancer, we excluded patients diagnosed after November 2010 to evaluate 2-year OS. A total of 37 patients were eligible for this assessment. Of these 37 patients, 12 (32%) were stage II, 13 (35%) were stage III, and 12 (32%) were stage IV. A comparison was made of bladder cancer cases at BUMC with averages of national cancer hospitals (Figure 3). At BUMC, overall 2-year survival was 83.3% among patients with stage II bladder cancer, 61.5% among patients with stage III, and 33.3% among patients with stage IV. These results were better at all stages in comparison with data from NCDB. The averages in NCDB were 54.7%, 45.8%, and 22.7%, respectively, for stages II, III, and IV bladder cancer. Again, these better numbers may be related to more aggressive therapies to treat bladder cancer.

**Conclusion**
Locally advanced, muscle-invasive bladder cancer is a challenging disease that requires a multidisciplinary approach, involving both urologists and medical oncologists. Despite aggressive local therapy, a significant portion of patients will eventually succumb as a result of distant metastases of the tumor. The integration of chemotherapy into the treatment regimen for locally advanced bladder cancer showed an improvement in survival, mainly due to the reduction in the rate of distant recurrence. Review of the data from the NCDB revealed that there is a suboptimal use of chemotherapy to aid control of locally advanced muscle-invasive bladder cancer. These findings are most likely a result of lack of coordination between different specialties, in addition to other medical comorbidities prohibiting chemotherapy use. The cooperation between urologists and medical oncologists to develop a thorough treatment plan is important to the well-being of these patients. BUMC strives to improve patient access to this collaborative approach and develop an aggressive program to treat patients with locally advanced, muscle-invasive bladder cancer. Moreover, BUMC promotes research opportunities with the hope of seeing continued improvement in patient survival from this disease.
Figure 3 Observed Survival Urinary Bladder Cancer: Baylor vs. NCDB

Cumulative Survival Rate

| Stage II (NCDB) | 100 | 82.8 | 69.9 | 60.8 | 54.7 |
| Stage II (BUMC) | 100 | 91.7 | 91.7 | 83.3 |
| Stage III (NCDB) | 100 | 80.6 | 63.7 | 52.9 | 45.8 |
| Stage III (BUMC) | 100 | 92.3 | 84.6 | 69.2 | 61.5 |
| Stage IV (NCDB) | 100 | 61.3 | 41.5 | 29.7 | 22.7 |
| Stage IV (BUMC) | 100 | 83.3 | 58.3 | 41.7 | 33.3 |

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

0.0 Yr. 0.5 Yr. 1.0 Yr. 1.5 Yr. 2.0 Yr.

Figure 3. Percent overall survival of patients with stage II (purple), stage III (green), or stage IV (blue) bladder cancer at Baylor University Medical Center at Dallas (BUMC; dotted line) versus the National Cancer Data Base (NCDB; solid line) over a 2-year period.

References

Bill Dippel: A Slam Dunk

When Bill Dippel turned 50, his physician recommended a screening colonoscopy. “I felt great. I had no symptoms, but he talked me into it,” Bill says. The test found a small polyp that turned out to be cancerous. At Baylor Charles A. Sammons Cancer Center, Bill underwent a colon resection, a surgical procedure that could be done laparoscopically because the cancer was found so early. A lymph node tested positive for cancer, so Bill also underwent six months of biweekly chemotherapy. “The doctors and nurses at Baylor were spectacular. They were smart, efficient, clear and candid, but really cared about me as a person.” Now Bill, an attorney and avid basketball enthusiast, is back in action.

“My treatment at Baylor was a slam dunk.”
Education

Fellowship Programs
In addition to patient care and research, education has been a prime objective of Baylor Charles A. Sammons Cancer Center since its opening in 1976. Oncology has emerged as one of the most exciting areas of medicine. Dedication to lifelong learning is important because new information constantly changes practice. During fellowship, trainees acquire the knowledge and skills required of a front-rank oncologist and the habits to continue their education in the future.

“Baylor University Medical Center at Dallas is a teaching institution, and this is one reason why the level of clinical excellence here is so high,” said Marvin J. Stone, MD, director of the medical oncology fellowship program.

More than 6,000 new cancer patients are seen at Baylor Sammons Cancer Center annually. The fellows thus become familiar with the design and interpretation of advanced treatments as well as conventional approaches.”

Mentorship is emphasized during the fellowship program, and many attending physicians are considered role models. Oncology rotations are designed so that each fellow spends one or two months with one attending physician. The large amount of one-on-one time between the fellow and the attending oncology physician maximizes the educational content for the trainees.

Fellows also spend time in blood and marrow transplantation, pathology, gynecologic oncology, and radiation oncology. More than 20 multidisciplinary site tumor conferences are held by Baylor Sammons Cancer Center each month. The discussions about diagnosis and treatment at these conferences provide fellows with valuable information and perspective about patient care. These trainees also attend a number of other oncology and hematology conferences with basic science, clinical research, and journal club formats. They engage in research projects, many of which develop into presentations at national meetings and published articles in peer-reviewed medical journals.

In addition to medical oncology, fellowship programs are offered in hematopathology, surgical breast oncology, breast imaging, and body imaging. All fellows have completed internal medicine training programs. Equipped with broad-based training and familiarity with the ongoing advances in the field, Baylor’s oncology fellowship graduates will be prepared to deliver quality and compassionate care to generations of patients.

Oncology Education Abroad
A group of health care professionals from Baylor University Medical Center at Dallas traveled to Vietnam February 21 to March
6, 2012, to work alongside local caregivers and introduce new concepts, teach new techniques, and identify needs that can be addressed on follow-up trips. The team from Baylor consisted of two experts in breast cancer (Drs. John Pippen and Cynthia Osborne), two general medical oncologists (Drs. Claude Denham and Nate Green, a former medical oncology fellow who now practices in Lincoln, Nebraska), a second-year oncology fellow (Dr. James Ewing), and an oncology nurse (Josie Divers, RN).

Planning for the trip began when physicians of Baylor Sammons Cancer Center and Texas Oncology were contacted by Health Volunteers Overseas (HVO). The American Society of Clinical Oncology has partnered with HVO to provide relevant training on oncologic diseases and health conditions in developing countries. In its quarter century of existence, HVO has sent more than 4,000 volunteers to places around the world and has completed close to 8,000 assignments.

The team was sent to Huế, a city in central Vietnam that serves as the capital city of the Thua Thien-Hue province. Due to its location near the border of North and South Vietnam, this South Vietnamese city was a site of intense fighting in the Vietnam War. Now a large peaceful city bisected by the Sông Hương (Perfume) River, Huế is home to approximately 950,000 residents and the Huế College of Medicine and Pharmacy.

Working within the college’s oncology clinic were the Vietnamese hosts, Dr. Nguyen Van Cau, a medical oncologist, and Dr. Phung Phuong, a surgeon. Dr. Cau had one oncology fellow who helped with patient care. At least 10 nurses and other assistants also staffed the clinic. The clinic was an air-conditioned building built in the 1980s. The first floor housed the Gamma Knife center, and the upper floors housed the clinics and inpatient hospital rooms. Dr. Phuong, a surgeon by training, had dual roles, as he planned, mapped, and operated the Gamma Knife, in addition to operating and serving as a clinical professor at the medical school. Dr. Cau’s office (where most of the patients were seen) was located on the second floor. Also on site was the small pathology department, with processing and microscope work done in the same room. Several basic immunohistochemical stains were available for breast cancer, although...
Ki67, an immunostain used to measure the proliferation index in breast tumor specimens, was not routinely used. The pathology reports did not always establish orientation and distance of the tumor from surgical margins. This was one issue the team addressed during their stay in Huế.

The gap in wealth in Vietnam is extreme. Those with connections to the Communist leaders live quite well, but the rest of the population lives in extreme poverty. Most drugs and health care are subsidized by the Vietnamese government; however, there is an exception with trastuzumab for HER2-positive breast cancer, which is unsubsidized. Rituximab is partially subsidized by the government and is for patients who can afford the large copayments. Dr. Cau was able to order almost any chemotherapy drug on the World Health Organization (WHO) list. He preferred epirubicin/paclitaxel as his adjuvant breast cancer regimen. For patients unable to afford rituximab, CHOP-etoposide was generally the preferred regimen for non-Hodgkin’s lymphoma.

The patients were treated in four inpatient rooms, each of which had five beds. Men and women were in the same rooms with no concern for privacy. If there were more patients than beds, the patients shared a bed, with one at each end. Each room had 5 to 10 patients, with their respective family members providing food and water. As in the inpatient rooms, patient confidentiality was not a concern in the clinic. As many as four breast cancer patients might be in the same room at the same time for their follow-up visit. Each disrobed and was examined in turn. It seems that patients often see the doctor for a very brief visit, lasting less than five minutes. Patients seemed to be in charge of holding their own records, and many would come in with their scans and radiology films in hand. Computed tomography and ultrasound were locally available and were performed quickly for the outpatients. The quality of the images was quite good. Positron emission tomography required a trip to Ho Chi Minh City or Hanoi, if the patient had the means to pay for it. Bone marrow transplant also required going to one of the two larger cities in Vietnam.

Once the team settled in to work in the clinic, they found an interesting and challenging mix of cases. Many types of cancer reflected what would be expected in a busy oncology clinic, with a tendency toward tobacco-related and gastric malignancies. Breast cancer and other malignancies seemed to present at a more advanced stage. This is probably related, at least in part, to the lack of screening or effective primary or secondary prevention programs. According to a 2010 WHO report, Vietnam is among the countries with the highest smoking rates in the world, with a prevalence of more than 45% in males aged 15 years or older. In addition, >40% of health care providers smoke. The high prevalence of smoking and cervical cancer relay the need for better primary prevention in Vietnam.

The area lacked a linear accelerator, which has been used for more than 50 years for external beam radiation treatments for cancer. Several local cancer recurrences could probably have been prevented if
standard radiation treatment had been given either concurrently with or after chemotherapy. Access to other types of radiation treatments would allow treatment of a much wider range of cancers.

The lack of palliative care and hospice represented a great need for the people of Huế, and it is a topic the team can explore on a subsequent trip. The use of long-acting narcotics was uneven. Patients at the end stage of their cancer and in a lot of pain could come to the clinic and receive injections of morphine, or a clinic nurse could go to them if they were nearby. Death was not discussed with patients; the family was simply told “to be prepared for anything.”

The trip to Vietnam was an educational experience, not only for the students and staff at the Huế Medical School and Oncology Clinic, but for every member of the Baylor team. The medical staff, students, and patients were extremely welcoming. Through them, the team learned how the medical system in Huế runs and how to make a difference in their medical practices. The group was able to list areas for improvement for future volunteer groups to address. Moreover, from their experience working with the medical staff in Huế, the team learned about resourcefulness and to be thankful for many things they take for granted, such as

Where Are They Now?

Baylor University Medical Center at Dallas prides itself on providing outstanding educational and training opportunities to prepare the physicians of tomorrow. To date, 50 physicians have completed the medical oncology fellowship program at Baylor Sammons Cancer Center at Dallas. Approximately two thirds of them practice in the North Central Texas community. We are pleased to announce that two former fellows of the graduating class of 2011 have joined the medical staff at Baylor Dallas: Micah Burch, MD, a hematology/oncology fellow, and Carolina Escobar, MD, a blood and marrow transplantation fellow.

Dr. Burch completed his internship and residency in internal medicine at Scott and White Hospital in Temple, Texas, followed by a chief residency in internal medicine. He specializes in hematologic malignancies, benign hematology, multiple myeloma, myelodysplasia, lymphoma and bleeding disorders. Dr. Burch is board certified in internal medicine and board eligible in medical oncology.

Dr. Escobar received her medical degree, with distinction, from Universidad Pontificia Bolivariana in Colombia. She served her internship at Emory University in Atlanta, Georgia and returned to Colombia to practice medicine. Dr. Escobar then returned to the U.S. to complete an internship and residency in internal medicine at LSU Health in Shreveport, Louisiana followed by a fellowship in hematology and oncology at the Feist-Weiller Cancer Center in Shreveport. She specializes in blood and marrow transplantation and is board certified in internal medicine, oncology and hematology by the American Board of Internal Medicine.
as state-of-the-art medical equipment, the availability of experienced specialists, and up-to-date medical training. All in all, it was an extremely worthwhile trip, and many participants plan on making it again.

_The Seeger Surgical Breast Oncology Fellowship 30th Anniversary_

The Seeger surgical breast oncology fellowship is in its 30th year at Baylor University Medical Center at Dallas. The fellowship was established with an endowment from Mr. and Mrs. Wirt Davis in honor of her parents, Helen Buchanan and Stanley Joseph Seeger. The program was originally headed by Harold Cheek, MD, the first surgeon in North Texas to limit his practice to diseases of the breast. At that time, it was the only surgical breast oncology fellowship in the country. Currently, 32 Society of Surgical Oncology–approved fellowship programs are available nationwide.

The Seeger surgical breast oncology fellowship is headed by Ronald C. Jones, MD, chief of surgery at Baylor Dallas. “We are training surgeons dedicated to surgical breast oncology, said Dr. Jones. “In addition, some fellows from the Baylor program finish and then go on to complete a residency in plastic surgery in order to perform breast reconstructive surgery. They thereby become the ‘total package’ for tumor removal and reconstruction.”

Since the program’s inception, 25 surgeons have completed the fellowship, including the four surgical breast oncologists currently on the medical staff at Baylor Dallas. “These former fellows are not only an integral part of our current program, but they also support breast oncology in the Dallas–Fort Worth area as well as the rest of the country, said Dr. Jones. “With the development of more breast cancer programs in the United States, we routinely get at least one inquiry a month from programs wanting to add a qualified surgical breast oncologist to their staff.”

_Site-Tumor Conferences_

At Baylor Sammons Cancer Center, a key element at the heart of our approach to patient care and education is the site-specific tumor conference program. Rather than focusing solely on recommendations for patient care, the site-specific conferences also aim at educating the medical professionals attending the conference. Unlike tumor boards, the site-specific tumor conferences offer continuing education and discussion of specific cases.
medical education credit for physicians who attend. Because several patients with the same diagnosis are presented at each conference, attendees are provided with an in-depth view from specialists, accompanied by lively discussion.

**Oncology Lectureships**

The fourth annual **Marvin J. Stone Lectureship** was held at internal medicine grand rounds on April 10, 2012, in Beasley Auditorium at Baylor University Medical Center at Dallas. This year’s recipient was Frederick R. Appelbaum, MD, director of the Clinical Research Division, Fred Hutchinson Cancer Research Center, and head of oncology, University of Washington School of Medicine. Dr. Appelbaum is also president and executive director of the Seattle Cancer Care Alliance, past chair of the Board of Scientific Advisors of the National Cancer Institute, and current chair of the Leukemia Committee of the Southwest Oncology Group. Dr. Appelbaum has authored more than 900 scientific publications and was lead author on the first paper to describe the successful use of autologous bone marrow transplantation in patients with refractory malignant lymphoma. Dr. Appelbaum’s presentation was entitled, “The Grand Challenges of Hematopoietic Cell Transplantation.”

The Stone Lectureship was instituted in 2009 in honor of Marvin J. Stone, MD, MACP. Dr. Stone served as chief of oncology at Baylor Dallas and director of Baylor Sammons Cancer Center from 1976 to 2008. He currently directs the medical oncology fellowship program and the internal medicine clerkship for third-year medical students.

The Department of Surgery held the annual **Harold Cheek Breast Lectureship** on April 11, 2012, in Davis Auditorium at Baylor Dallas. This year’s lecture featured Kelly K. Hunt, MD, FACS, chief, division of surgical breast oncology at M. D. Anderson Cancer Center and Hamill Foundation Distinguished Professor in the Department of Surgical Oncology at the University of Texas. Dr. Hunt presented “The Changing Role for Auxiliary Surgery in the Management of Breast Cancer.”

The **Lloyd Wade Kitchens Lectureship** was held on August 28, 2012, in Beasley Auditorium at Baylor Dallas. The featured speaker was Dennis M. Kratz, PhD, Dean, School of Arts and Humanities, Ignacy and Celina Rockover Professor of Humanities at the University of Texas at Dallas. Dr. Kratz’s lecture topic was “The Art at the Heart of Healing.”

**Fellows’ Research**

**Management of Metaplastic Breast Cancer: Clinicopathologic Features, Prognosis, and Response to Therapy**

Carolyn L. Thomas, MD, a breast surgery fellow at Baylor University Medical Center at Dallas, was selected for a poster presentation at the 36th Annual Symposium of the American Society of Breast Diseases in April 2012. The Metaplastic Breast Cancer poster was also presented at the North Texas Chapter of the American College of Surgeons in February. Dr. Thomas performed a retrospective review of 41 patients diagnosed with metaplastic breast cancer and treated at Baylor between 1993 and 2010. Patients were identified through the Cancer Registry and were reviewed for clinical and pathologic features, as well as treatment and outcomes. Although other studies have demonstrated lower overall survival and disease-free survival with metaplastic breast cancer compared with invasive ductal breast cancer, the Baylor study cohort experienced fewer local and distant disease recurrences than has been observed in other studies.

**Continuing Medical Education Symposia**

An important function of Baylor Charles A. Sammons Cancer Center at Dallas is to serve as a regional center for continuing
medical education for health professionals. This is accomplished by offering day-long symposia that present the latest information in the prevention, screening, evaluation, and management of specific cancers. Expert faculty on the medical staff at Baylor University Medical Center at Dallas and from other institutions across the country provide up-to-date presentations as well as one-on-one discussion time with attendees. Two symposia have been presented in 2012 on lung cancer and gastrointestinal (GI) cancer.

The inaugural GI Surgical Cancer Conference was held Feb. 11, 2012. This event focused on the diagnosis, treatment, and management of GI cancers and was attended by 70 medical professionals from across North Texas. Expert faculty from Baylor lectured on esophageal and gastric cancers, diseases of the pancreas, and GI malignancies, genetics, and postoperative care. The keynote speaker was Herbert Zeh, MD, assistant professor of surgery in the Division of Surgical Oncology at the University of Pittsburgh, as well as the codirector of the University of Pittsburgh Cancer Institute Pancreatic Cancer Center. Dr. Zeh is one of the country’s leaders in the use of the da Vinci® Surgical System for robotic pancreatic surgery. This technology allows minimally invasive surgery that enhances the surgeon’s ability to see details and allows for more natural movements in performing the Whipple procedure, one of the most complex surgeries performed to treat pancreatic cancer. At his institution, this type of robotic procedure compared with more traditional methods has resulted in a
open discussions led by a moderator were initiated after each group of talks, allowing the participants to ask questions of either a particular speaker or the panel of speakers. Cases were presented, and an audience response system was utilized to enhance the interaction.

**Education in Palliative and End-of-Life Care**

One of the most difficult tasks for an oncologist is to discuss end-of-life issues with a family when the patient is unable to communicate his or her wishes. This is why it is so vital for all people, not just cancer patients, to have an advance directive. An advance directive is more than just a living will; it can also include medical power of attorney and an out-of-hospital do-not-resuscitate order. Patients may decide to have one, two, or all three of these legal forms as part of their medical file in preparation for their potential need for end-of-life decisions.

A recent inpatient survey of oncology units at Baylor University Medical Center at Dallas found that less than 30% of patients had ever had a discussion with their oncologist regarding their wishes “if they were to become very ill or close to dying.” Moreover, less than 60% of these hospitalized patients had an advance directive. To improve the physicians’ ability to communicate end-of-life issues and advance planning to patients, a one-day interactive program modeled after the EPEC™-O program (Education in Palliative and End-of-Life Care for Oncology) was offered to oncologists. This program was coordinated by Mark A. Casanova, MD, a member of the palliative care team at Baylor Dallas.

The initial course, with 18 participants, offered three presentations by Dr. Casanova on communication, negotiating goals of care and advanced care planning. Each session was followed by interactions of the oncologists with standardized patients, who progressed through their illness with each session. All of the oncologist-patient interactions were taped, and the class viewed several tapes after each session and the remaining at the end of the day. Dr. Casanova asked physicians to critique themselves, and then he and the group discussed the salient issues for each interaction. This course allowed oncologists to not only watch how they might be viewed interacting with patients, but also see how other oncologists handled similar situations. The participants gave good reviews for the course and found it beneficial to improving their practice. This course has been presented twice, and there are plans to continue it, perhaps modify it for other members of the health care team, and offer it in select locations across the Dallas–Fort Worth Metroplex to facilitate attendance of oncologists on the medical staff across Baylor Health Care System.
Laura Granado: A Full and Healthy Life

Because her sister had breast cancer, Laura Granado decided to go through the Hereditary Cancer Risk Program at Baylor Charles A. Sammons Cancer Center at Dallas. Genetic testing showed she was at high risk for breast and ovarian cancer. She discovered a lump and after a biopsy was diagnosed with breast cancer. At Baylor Dallas, Laura underwent a double mastectomy followed by reconstructive surgery. “I had great support from the hospital staff. My nurse navigator was awesome. She listened to me and told me everything to expect.”

Laura is back to work and taking care of her family. “Thanks to Baylor, I’m living a full and healthy life.”
Research

Hope for Advanced Melanoma: New Developments in Cancer Vaccines

Patients with resected stage IIIc/IV melanoma have a poor prognosis; treatment options are limited, and five-year survival rates are less than 30%. Karolina Palucka, MD, PhD, investigator and the Michael A. E. Ramsay Chair for Cancer Immunology Research at Baylor Institute for Immunology Research, has been working for more than 10 years developing and testing vaccines for the treatment of advanced melanoma. To date, although a significant proportion of patients have developed a tumor antigen–specific immune response, only a few have shown a durable objective tumor regression. Dr. Palucka is now using funding from Baylor Sammons Cancer Center's Research Grant Program to explore a new approach to vaccine development that may point the way to more effective treatment.

Most of the vaccines developed by Dr. Palucka have involved dendritic cells (DCs), the master controllers of immune processes in the human body. A key characteristic of DCs is their plasticity: they will mature differently and have different capabilities in response to different growth factors and cytokines. Langerhans cells (LCs), which are found in the epidermis, prime high-avidity, antigen-specific CD8+ T cells. These T cells are critical for a long-lived protective immunity that will prevent relapse in patients with high-risk disease. Interstitial dermal CD14+ DCs, on the other hand, are important in the generation of humoral immunity, including the production of antibodies and memory B cells. The most efficient vaccines may be those that target both types of DCs, allowing stimulation of both cellular and humoral immune responses.

For vaccine development, either CD34+ progenitor cells or monocytes are removed from the patient's blood by apheresis and grown in culture with selected growth factors that affect differentiation and maturation. The resultant DCs are loaded with tumor-specific antigens before being inoculated back into the patient. In earlier studies, Dr. Palucka discovered that monocytes that differentiate into DCs in response to the cytokine interleukin-4 (IL-4) differentiate into interstitial dermal DCs, whereas treatment with IL-15 leads to the generation of cells with the properties of LCs.
Testing the effectiveness of an IL-15 vaccine has posed several problems. It is a difficult cytokine to produce and has only recently become available commercially. In addition, IL-15–induced DCs are more fragile than ordinary DCs and require special handling in the laboratory and clinical settings. Dr. Palucka has surmounted these difficulties and is now testing the immunogenicity of IL-15 DCs in patients with advanced melanoma in a pilot study cofunded by Baylor Sammons Cancer Center’s Research Grant Program and by the National Institutes of Health. The IL-15 DCs are loaded with nine to ten amino acid peptides derived from four melanoma antigens. In addition to monitoring vaccine immunogenicity after two weeks, the study will examine progression-free survival and overall survival at 92 weeks.

If the results of the trial are positive, it will provide another piece of the puzzle that Dr. Palucka has been putting together over the last 10 years—how to provide long-lived protective immunity against a deadly cancer. “We are in a revolutionary phase in developing immune therapy for cancer. We are seeing some amazing responses in patients with lung cancer and pancreatic cancer who were classically considered to be untreatable. We are really entering a new area, where immune therapy will become an everyday treatment of cancer,” said Dr. Palucka.

**Research in Breast Surgical Oncology: On the Lookout for Practice-Changing Results**

A key component in maintaining the quality of breast surgical oncology is the incorporation of the latest research findings into day-to-day practice. This may involve a clinician’s active participation in clinical research studies, but it equally involves awareness of potentially practice-changing research being conducted around the country and around the world.

Sentinel lymph node (SLN) biopsy has become the standard of care for breast cancer management, but many questions remain as to best practices for this technology. Intraoperative assessment of the SLN typically involves touch imprint cytology or frozen section stained with hematoxylin and eosin (H&E). Permanent section may use immunohistochemical staining in addition to H&E, allowing the identification of extremely small lesions (isolated tumor cells, defined as lesions not larger than 0.2 mm in diameter) that may not be visible
with H&E. How frequently would the treatment recommendation be made on the basis of intraoperative pathology change after analysis of permanent sections? Are the types of lesions identified clinically important?

Michelle Shiller, DO, MSPT, a pathologist on the medical staff at Baylor Dallas, has worked with surgeons to collect data for two studies. In the first study, 488 consecutive SLN biopsies were retrospectively reviewed to determine the accuracy of intraoperative pathology compared with permanent section in identifying lesions in the SLN. The findings from this study, which were published in the April 2011 issue of *Baylor University Medical Center Proceedings*, indicated that the sensitivity and specificity of SLN biopsy at Baylor University Medical Center at Dallas compared favorably with percentages reported in the literature. For macrometastases (lesions >2.0 mm), the sensitivity was 88%; for micrometastases (lesions 0.2–2.0 mm), the sensitivity was 72%; and for isolated tumor cells, the sensitivity was 60%. Specificity was 100% in all cases.

Dr. Shiller is now involved with a follow-up study entitled “A retrospective evaluation of the sensitivity and specificity of diagnosing axillary lymph node status: bridging pathologic diagnosis with clinical outcomes over 5 years” (Baylor Research Institute IRB #011-175). This study is reassessing the original patient group to determine how pathology results influenced the clinical management of the patients. The study will determine if patients with a finding of micrometastases or isolated tumor cells underwent an axillary lymph node dissection, and if not, why. It will also reassess the status of the SLN as a prognostic indicator by examining disease-free survival, recurrence, and occurrence of ipsilateral or contralateral second primary tumors. The data from this study are being acquired now and will contribute to a breast cancer registry that will ultimately be incorporated into the new surgical oncology clinical research database.

In assessing the latest research findings presented at national meetings, clinicians must judge carefully whether a study is potentially practice changing. Barry Wilcox, MD, a radiation oncologist on the medical staff and medical director of radiation
oncology at Baylor Dallas, commented on a recent clinical trial that attracted attention at the 2010 meeting of the American Society of Clinical Oncology. In this study, 636 patients with early stage, estrogen receptor–positive breast cancer who were 70 years of age or older were randomized to receive either tamoxifen alone or tamoxifen plus radiation after lumpectomy. At 10.5 years follow up, the addition of radiation resulted in a 6% reduction in recurrence, but no difference in survival. These results were much anticipated, but they are not necessarily practice-changing, according to Dr. Wilcox. “These results present an additional treatment option for older women. Radiation therapy is typically offered to patients over 70, but discussion with the patient has to be individualized as to the risks and benefits that apply for that specific patient. Many women are just not keen on taking radiation therapy. They may have significant comorbidities or have difficulty in getting to and from the cancer center for daily treatments over a five- to six-week period. Whatever the reason, they would like to know if they are putting themselves at serious risk by saying ‘no.’ We now have data to give them some solid information.”

**The Surgical Oncology Research Database: One-Stop Shopping for High-Quality Clinical Patient Data**

Two years ago, the Division of Surgical Oncology was created as an academic subunit of the medical staff at Baylor University Medical Center at Dallas. This new division was created to increase the academic activities of clinical surgeons and to provide infrastructure for the support of clinical research. Currently, the division has 18 surgeons as members. The progress on the creation of the research database will support the development of new avenues for research in the cancer center.

One of the major assets of housing the research database at Baylor Dallas is the contribution to the research enterprise. This large patient base is the foundation for the continued excellence in patient care. Until now, however, it has been difficult for a researcher to collect patient data for a study because the data is housed in various locations:

- Baylor Sammons Cancer Center maintains a tumor registry on patients treated at the center, including information on cancer type, site, disease stage at diagnosis, type of treatment, and treatment outcomes.

- The Enterprise Data Warehouse (EDW) is a central repository of Baylor information used to support enterprise analytics, reporting, and research. The database contains information from data sources across the enterprise, including patient demographics, ADT (Admit, Discharge, Transfer), financial, clinical, and operational systems. Data are extracted from multiple systems and then structured and organized in a manner which allows the various types of information to be analyzed at various levels of detail. Information in the EDW is presented through a variety of methods, including executive dashboards, operational scorecards, and scheduled and ad hoc reports.

- The Department of Pathology at Baylor Dallas works closely with surgical oncologists to provide diagnosis, assessment of adequacy of surgical resection, and additional information about prognosis that may influence treatment decisions. According to George Snipes, MD, PhD, medical director of Molecular Pathology at Baylor Dallas, reports that the department is currently capable of running antibody tests for 200 different proteins, approximately 1% of the protein complement of the human genome. The department can isolate DNA and RNA from surgical specimens to look for mutations in oncogenes and tumor suppressors. As more biomarkers of specific targeted pathways are identified, more information will be collected.

- Physician practices including Health Texas Provider Network, Texas Oncology, PA, Neuro Oncology Associates, Pathologists Biomedical Labs, etc.

To facilitate the research process, the Division of Surgical Oncology is continuing the development of the Surgical Oncology Clinical Research Database, or SOCRD. SOCRD will serve as a meta-registry, where multiple databases can be connected in a useful way. The database will provide a central location where information from all these sources can be stored, validated, and accessed for clinical research.

Clinicians and information technology experts from Baylor Dallas have worked with an outside vendor to complete a
“proof of concept” beta test of the meta-registry, drawing initially on data from the EDW, tumor registry, and pathology systems, and focusing on individual tumor sites. With the successful completion of that test, phase II of the development was launched on December 1 of 2011; it incorporates additional registries and 52 tumor sites (i.e., breast, colon, hepatocellular carcinoma, etc.). These registries and data sets are continuing to be validated; however, multiple registries within SOC RD are already in production.

The working group from Baylor Dallas includes Drs. Preskitt and Snipes, Angelia Drake, program manager of the Division of Surgical Oncology, Jennifer Peattie, clinical applications manager with Annette C. and Harold C. Simmons Transplant Institute, as well as a team of division members, Baylor’s Information Systems (BIS), and experts, including surgeons Scott Celinski, MD, Keith Cavaness, DO, John C. O’Brien, MD, Michael Grant, MD, and Robert Goldstein, MD, and pathologist, Michelle Shiller, DO, MSPT. They are working together on the infrastructure of the database, building it to be comprehensive, robust, and dynamic, while maintaining HIPAA-required confidentiality and regulatory requirements. “The protection of confidential information is critical, and we will guarantee that protection through a disciplined and scientific methodology in how we put things into and pull them out of this meta-registry,” said Dr. Preskitt.

One of the tools which is used to protect confidentiality is the use of de-identified data. According to Angelia Drake, a
A long-term goal for SOCRD is to include a de-identifying tool which allows the physician-investigators to query de-identified subjects/data to determine counts or confirm a hypothesis before obtaining IRB approval. For example, a physician interested in a clinical question about a specific patient group (e.g., women over 50 with advanced breast cancer who smoke) could query the system to determine the number of patients meeting these criteria. If the results of the de-identified data obtained supports pursuing a clinical study, they would be brought to the division’s Research Committee for review/approval to move forward with development of the study and the IRB process.

While SOCRD was initially populate with a core set of data, the database also includes several modules, such as a registry builder and a configuration tool which enables the building of individual registries, a query builder which allows us to perform ad hoc and standard queries, and a dashboard builder which supports viewing the data for clinical research. Additional sources of data will come into the database, including data from clinical trials, follow-up data on patients, quality-of-life surveys, etc. “This will be a dynamic database,” said Dr. Snipes. “We need to follow patients for as long as we can. We won’t be closing too many files.” He qualified this; however, to take into account studies which require that data not be changed, “In some cases, such as drug trials, we need to lock down the data. In order to achieve this, we will take ‘snap-shots’ at various times, while still maintaining the fluid quality of the database.”

As mentioned, SOCRD is being developed in cooperation with an outside vendor, Remedy Informatics (aka RemedyMD), who will also be involved in long-term management of the database and training sessions for database users at Baylor Dallas. Similar vendors have been involved in the establishment of meta-registries for Cleveland Clinic, University of California-Davis and University of Texas-Southwestern. SOCRD will utilize cloud storage provided by Amazon, so the amount of data which can be added will be limited only by budgets, not by technology.

Everyone involved with SOCRD is excited about the potential of this new tool to facilitate research at Baylor Dallas. “SOCRD will provide a rich source of clinical information,” said Dr. Snipes. “In this era of precision medicine, if we can connect our pathologic data with outcome data, we can do a better job of identifying and validating new molecular markers.” Dr. Preskitt believes SOCRD will be an important tool in recruiting young, well-trained surgical oncologists to Baylor Dallas. “Baylor is attractive to them because of our large and diverse patient population. But they are looking for a more academic environment, and SOCRD is going to be a major step in that direction,” said Dr. Preskitt.

**Progress of Research Grants**

In 2012, Baylor Charles A. Sammons Cancer Center at Dallas awarded six grants to investigators, for a total of $642,000. The award category, investigators, and grant titles are listed below.

**Pilot Projects**

Three projects sought to generate initial data so that the investigator could successfully prepare an application for extramural peer-reviewed funding. The investigators and their grants were as follows: Ajay Goel, PhD, “Development of novel epigenetic biomarkers for predicting therapeutic outcome in patients with advanced colorectal cancer”; Cynthia Osborne, MD, “Effect of exercise during adjuvant chemotherapy infusion for breast cancer;” and Ariane Theiss, PhD, “Metabolite profiling of disease progression in colitis-associated cancer.”

**Emerging Technology Projects**

These grants through the Baylor Research Institute provide funding to investigators to access emerging technology, such as genomics, proteomics, and metabolomics, which require advanced equipment or technology not readily available to them. Rather than obtain the equipment or technology, the investigators use these funds to pay for the tests. Joyce O’Shaughnessy, MD, had one grant in this area entitled “Comprehensive phosphoproteome pathway analyses of metastatic breast cancer tissues that have undergone whole genome and transcriptome sequencing.”

**Trainee Grants**

These grants provide funding to residents and fellows in a Baylor Health Care System–approved postgraduate training program conducting a research project involving the treatment, diagnosis, or etiology of cancer. Graduate students working in a Baylor Research Institute laboratory
with a Baylor investigator as their primary mentor are also eligible. Meghan Koch, DO, received an award for a project titled "Methods of sample preparation for high-resolution mass spectrometry in patients with ovarian cancer."

**Clinical Oncology Research Coordination Office**
The Clinical Oncology Research Coordination Office experienced its second straight year of continued growth in 2012. The office manages more than 100 active protocols, of which 68 are open to enrollment at three Baylor locations, Baylor University Medical Center at Dallas, Baylor All Saints Medical Center at Fort Worth and Baylor Medical Center at Irving. Trials are available for a variety of tumor types, including hematologic malignancies (leukemia, lymphoma, and multiple myeloma), bone marrow transplant, breast cancer, melanoma, lung cancer, brain cancer, head and neck cancer, and gynecologic malignancies including ovarian, fallopian tube and endometrial cancer. The office also continues to support several cooperative groups and consortia, including the Southwest Oncology Group, Gynecologic Oncology Group, Multiple Myeloma
In 2012, the number of open trials increased by 55%. As a result, enrollment in oncology trials increased by 26%. A goal for the coming year is to increase enrollment in clinical trials by 10% and increase the number of trials available to patients by 10%.

**Contributions at the American Society of Clinical Oncology Meeting**

At the 2012 meeting of the American Society of Clinical Oncology, 32 abstracts featured authors from Baylor Sammons Cancer Center. Baylor Sammons researchers were first authors on seven abstracts—three by Thomas E. Hutson, DO, PharmD, two by Joyce O’Shaughnessy, MD, and one each from Carlos Becerra, MD, and Cynthia Osborne, MD. Twelve of the 32 abstracts related to genitourological cancers; nine to breast cancer; three to gastrointestinal cancers; three to early phase trials; two to neurological cancers; two to melanoma; and one to sarcoma.
2012 List of Publications


2. Antelo M, Balaguer F, Shia J, O'Shaughnessy J. Overall Survival of two different doses of capecitabine in phase II non-inferiority study (NO16853) of the NO16853 trial group. Randomized phase II non-inferiority study (NO16853) of the NO16853 trial group. Randomized


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59. Shahrar R, Alexander CT, Quirk CR, Kegovlits V, Vanrucken M. Numb chin syndrome as the initial presentation of post-transplant lymphoproliferative disorder.


Philanthropy

Baylor Health Care System already has enviable recognition in safety, quality, strong leadership, and clinically advanced bedside care. It also has a strong history of philanthropic support. But excellence is perishable. Sustaining it requires not just stewardship, but innovation and investment. Through the generous support of philanthropic leaders in our community, Baylor has the opportunity to define the future of cancer care in North Texas.

Over the past year, Baylor Health Care System Foundation has raised more than $3 million in support of cancer initiatives at Baylor. These funds have been used to support patient-centered programs like patient navigation and the Virginia R. Cvetko Patient Education and Support Center; to further our research and conduct clinical trials that offer potential life-altering results for the patients we serve today; to purchase the latest technology and capital equipment that advance treatments and nurture healing; and to recruit and train the best and brightest physicians of the future.

Philanthropy allows us to continue our services uninterrupted, to make the necessary investments and to maintain the qualities that make Baylor unique and special. And that makes us all better.

**T. Boone Pickens' $10 million Investment in Baylor**

In September, Baylor Health Care System Foundation announced that legendary oil and gas entrepreneur and philanthropist T. Boone Pickens pledged $10 million in support of Baylor initiatives. In recognition of this gift, and in a move that links the innovative business leader with a leading cancer program, Baylor honored Boone by naming its new cancer hospital Baylor T. Boone Pickens Cancer Hospital.
“No matter what industry you’re in, from energy to health care, it takes bold people who have vision, a commitment to excellence, and a passion for efficiency to reach new levels of success,” said Pickens. “Baylor brings that attitude and commitment to providing health care to all North Texans, whether it is advanced prevention, screening, diagnosis, or treatment.”

At Baylor T. Boone Pickens Cancer Hospital, Pickens and Baylor honored the donor’s 50-year friendship with the late Harley Hotchkiss, a fellow oilman, philanthropist, and former owner of the NHL Calgary Flames. Two years ago, Harley traveled from Canada to Baylor to seek treatment for his late-stage prostate cancer. Unfortunately, his disease was advanced, and in June 2011, he passed away. A plaque at the cancer hospital commemorates Pickens’ lifelong friendship with Harley.

“T. Boone Pickens’ gift reinforces that Baylor is a world-class health care system. It provides a valuable platform for us to talk about Baylor’s defining culture and to show the positive impact we have in our communities. We are excited and honored to have a relationship with a leader known for giving to institutions aligned with a focus on caring for the whole patient. We are proud of his endorsement,” said Rowland K. Robinson, president of Baylor Health Care System Foundation.

**2012 Celebrating Women Luncheon**

Baylor Health Care System Foundation hosted its 13th annual Celebrating Women luncheon in October at the Hilton Anatole hotel in Dallas. Celebrating Women has raised more than $19 million over the past 13 years to benefit Baylor Health Care System’s breast cancer initiatives.

The keynote address, delivered by award-winning actor and best-selling author Rob Lowe, was enjoyed by more than 1,350 luncheon attendees. After losing his mother, grandmother and great-grandmother to breast cancer, Lowe has been a passionate advocate for research and early detection.

The event, chaired by Pam Busbee and Pam Perella, recognized Mary Anne Cree and the men and women of Sammons Enterprises, Inc. with the Circle of Care Award. The award is given to those who have served as advocates, volunteers,
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The Joan Horner Interfaith Prayer Garden

Gardens are inspirational, healing, restorative, and beautiful. They can be a sight to behold, boasting vibrant colors and hearty greenery. And thanks to a generous gift from the Joan and Andy Horner Family, we will all be able to enjoy the natural beauty and tranquility of a new interfaith garden, located in the heart of Baylor University Medical Center at Dallas, by late next spring, 2013.

The Joan Horner Interfaith Prayer Garden will feature natural limestone pathways and abundant planting, where water features on both sides of the garden will generate soothing background noise and help provide privacy. The garden is designed with quiet nooks and seating for prayer and contemplation and is centrally located so
patients staying in any of the hospitals at Baylor Dallas can see the garden from their rooms. The original garden was donated by the Wayne Family Foundation and will be expanded in new and different ways, while still incorporating Bradley and Ernestine Wayne's legacy.

Over the years, the Horners have been loyal supporters of the Foundation, and their generous gifts provided significant support for a number of Baylor’s cancer programs. The Horner Family Chapel in the Baylor Charles A. Sammons Cancer Center was named in recognition of their support.

**Boon Family Crusade for Cancer Research**

E. K. Boon was diagnosed with renal cell carcinoma in 1992. During his battle with the disease, he participated in a genetics research program through his physicians on the medical staff at Baylor Health Care System. His physicians advised him that his disease was too far advanced for the research to save his life; however, E. K. was confident his efforts would contribute to saving the lives of other cancer patients. When E. K. lost his battle with cancer in 1996, his family wanted to continue his legacy and contribute to finding a cure. To that end, they held their first cancer benefit golf tournament in 1997 in memory of E. K., with all proceeds going to cancer research at Baylor.

This September, the Boon family celebrated their 14th tournament. In all, this tournament has raised nearly $700,000 in support of cancer research at Baylor.

“Clinical trials give patients hope when standardized therapy is no longer working. To be a destination cancer center, we must be a driver in clinical trials, and that is our goal,” said Rowland K. Robinson, president of Baylor Health Care System Foundation. “We appreciate the Boon family’s continued support and partnership in this fight against cancer.”
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• Screening mammography
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• Breast cancer prevention
research trials
• Breast Care for Lifetime™
• Breast health education
• Personal risk evaluation
Cancer Genetics Program
• Breast and ovarian 214.820.9600
• Gastrointestinal 214.820.2692
Integrative Medicine Program 214.820.2608
Liver and Pancreas Disease
Center 214.820.1756
Lymphedema Prevention and
Treatment Services 214.820.6767
Oncology Outpatient Clinic 214.820.6767
• Bone and Soft Tissue Tumor Clinic
• Cardiology Services
• Dental Clinic
• FitSteps for Life®
• Head and Neck Clinic
• Physical Medicine and Rehabilitation
• Radiology Services
• Skin Cancer Screening Clinic
• Skull Base Clinic
• Speech Therapy
• Supportive and Palliative Care Services
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Patient Navigation 214.820.3535
Marketing and Public Relations 214.820.2116
Ernie’s Appearance Center 214.820.8282
• Prostheses and specialty
care items for cancer patients
• Nutraceuticals
Sammons Events and
Community Relations 214.818.8473
Screenings 214.820.6767
• Head and neck cancer (April)
• Skin/melanoma (monthly)
Smoking Cessation Program
• Dental Clinic—Oncology
Outpatient Clinic 214.820.6767
• Martha Foster Lung Care
Center 214.820.9791
Virginia R. Cvetko Patient
Education and Support
Center 214.820.2608
• Patient/family education
and support programs
• Patient resource centers/ oncology libraries
Baylor Health Care System
Valet Parking 214.820.8077
Patient Transport 214.818.6400

US Oncology/Texas Oncology
Research 214.370.1000
Joanne L. Blum, MD, PhD,
Site Leader
Campus and Area Maps

Baylor Sammons Cancer Center and Baylor T. Boone Pickens Cancer Hospital are located on the campus of Baylor University Medical Center at Dallas, and are accessible from U.S. 75 (North Central Expressway/I-45) and I-30.

A map on the facing page illustrates highway access to the medical center.

Valet parking is available at the front entrance and other nearby locations.

Self-parking is conveniently located adjacent to Baylor Sammons Cancer Center in garage 4.

Self-parking for the new Baylor T. Boone Pickens Cancer Hospital is available in garage 4 or valet in front of the hospital.

The campus is also accessible via the DART Green Line to Baylor University Medical Center station. Baylor Sammons Cancer Center is a two-block walk.