



METHODIST |
ESTABROOK CANCER CENTER |

The background of the page is a solid blue color with several large, overlapping, curved lines in a lighter shade of blue, creating a sense of motion and depth. The lines curve from the top left towards the bottom right.

2011 Annual Report



Daniel D. Lydiatt

A cancer diagnosis is life-changing.

At Methodist Estabrook Cancer, we understand that cancer affects not only physical health, but also mental and emotional health, spirituality, self-image, relationships, career, finances and more.

This is why we embrace a comprehensive and holistic approach to cancer care. For us, medical excellence is only the beginning. We also offer an ever-expanding menu of customized support services to improve the everyday lives of cancer survivors and their families.



Josie Abboud

This year we are especially proud to announce the opening of Inner Beauty: A Specialty Salon for Cancer Survivors, a new Harper's Hope service made possible through a generous donation to Methodist Hospital Foundation. Inner Beauty's clinical cosmetologist is specially trained in helping patients reclaim confidence, comfort and control over appearance and sense of self throughout the cancer journey.



Patty Bauer

In support of physical wellness, we have added our first daytime yoga session and expanded yoga classes to a twice-weekly format. Thanks to the completion of our most recent renovation, yoga and other physical wellness classes are now held on-site in our spacious lower level multipurpose room.

Occupational therapy and lymphedema services have been brought on-site as well for greater convenience and continuity of care. Another significant support service is provided by a new patient financial counselor dedicated to serving cancer patients, and, for the first time, housed within Methodist Estabrook Cancer Center.

We thank you for your interest and support. Our battle against cancer continues, as does our unwavering support for those whose lives are changed by cancer.

Daniel D. Lydiatt, DDS, MD
Medical Director
Methodist Estabrook Cancer Center

Josie Abboud, RN, BSN, MBA
Vice President
Ancillary and Clinical Services

Patty Bauer, BS, RN, RRT
Service Executive
Methodist Estabrook Cancer Center

Head & Neck Surgical Oncology

Russell B. Smith, MD, FACS

Dramatic changes occur each year in our understanding of cancer. With ground-breaking research, we better understand the way cancer starts and spreads, and subsequently we can develop better ways to treat cancer.

In the head and neck, the most dramatic changes in our understanding of cancer have been for tumors that occur in an area called the oropharynx. The oropharynx is the part of the throat located behind the mouth that includes the tonsil, the base of tongue, and the soft palate.

In the past, oropharyngeal cancer typically occurred in men who had a long history of tobacco and alcohol use. These patients were usually in their fifties or sixties and went to see the doctor because of a sore throat, ear pain, and difficulty swallowing. Today, most patients with oropharyngeal cancer fit a different profile and have very different complaints.

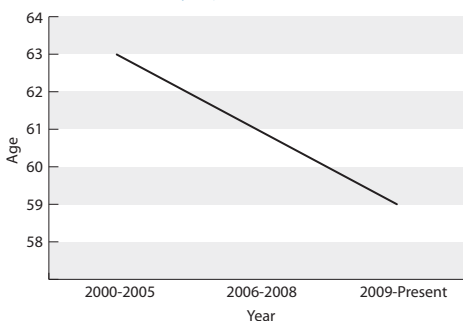
Patients with oropharyngeal cancer now tend to be much younger and frequently have never used alcohol or tobacco. We have seen this same trend at Methodist Estabrook Cancer Center. (Table 1)

The patients also usually have no throat or ear problems and seek medical care because of a mass high in the neck just below the jaw. Because of these changes, researchers began to look for different reasons why oropharyngeal cancer occurs.

This research has found that in addition to alcohol and tobacco use, previous infection with a virus called human papillomavirus (HPV) is a major cause of oropharyngeal cancer. HPV is a virus that has many different types. Some types can cause warts; others can cause cancer. In addition to being a cause of oropharyngeal cancer, HPV is the most common reason for women to have uterine cervical cancer.

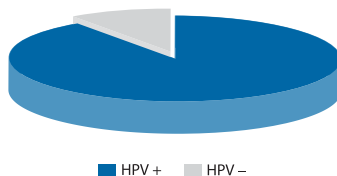
Table 1

Age of Diagnosis of Oropharyngeal Cancer at MECC



We currently run special tests on the tumors of patients with oropharyngeal cancer looking for HPV. From 2009-2011, nearly 90 percent of new oropharyngeal cancers diagnosed and treated at Methodist Estabrook Cancer Center were positive for HPV (Table 2).

Table 2
HPV in Oropharyngeal Cancer at MECC



In addition to patients with HPV-positive oropharyngeal cancer being younger and having fewer symptoms, the presence of HPV also has a dramatic effect on a patient's chance of cure following treatment. Researchers have shown that in non-smoking patients with HPV-positive tumors, the 3-year survival rate is over 90 percent. For patients with HPV-negative tumors, the 3-year survival rate is much worse at only 46 percent. For patients with HPV-positive tumors, smoking does have a negative effect, decreasing the 3-year survival to 70 percent. (1)

Major changes in the treatment of oropharyngeal cancer have also occurred over the last decade. In the early 2000s, many patients with oropharyngeal cancer would be offered chemotherapy and radiation therapy for treatment. This approach was used with the hope of eliminating the side effects of surgery while offering the same or an even better chance of cure. Cure rates have been excellent when a combination of chemotherapy and radiation therapy was used to treat oropharyngeal cancer, but unfortunately, patients still have

Figure 1



Transoral Robotic Surgery for Treatment of Oropharyngeal Cancer.

severe side effects from treatment which can make swallowing very difficult.

In the last two to three years, there has been a shift back toward using surgery more frequently in the treatment of oropharyngeal cancer. These surgeries are considered minimally

invasive and use the surgical robot or lasers to remove the throat tumor through the mouth (Figure 1). While outcomes using this approach are early, it appears that for certain patients that this may be a great option for therapy.

1. Ang, KK, Harris, J, Wheeler, R, et al. Human papillomavirus and survival of patients with oropharyngeal cancer. NEJM 2010;363:24-35.

2010 Cases

Primary Sites	Total	Analytic	Non-Analytic
LIP	7	5	2
TONGUE	36	34	2
GUM	13	13	
FLOOR OF MOUTH	8	8	
PALATE	3	3	
MOUTH	13	10	3
PAROTID GLAND	4	4	
SALIVARY GLAND	2		2
TONSIL	19	17	2
OROPHARYNX			
NASOPHARYNX	4	4	
PHRIFORM SINUS	4	3	1
HYPOPHARYNX	2	2	
ORAL CAVITY	2	2	
ESOPHAGUS	10	10	
STOMACH	18	17	1
SMALL INTESTINE	13	12	1
COLORECTAL	119	105	14
ANUS	10	9	1
LIVER	6	6	
GALLBLADDER	2	2	
BILIARY TRACK	4	4	
PANCREAS	26	26	
NASAL CAVITY	2	1	1
SINUS	5	5	
LARYNX	22	15	7
TRACHEA			
LUNG	166	159	9
THYMUS	1	1	
HEART-PLEURA-MEDIASTINUM	5	5	
BONES-JOINTS-CARTILAGE	3	3	
BLOOD SYSTEM	41	33	8
CLL	9	5	4
ALL	3	3	0

2010 Cases (continued)

Primary Sites	Total	Analytic	Non-Analytic
SKIN	89	83	7
MELANOMA	82	76	7
AUTONOMIC NERVOUS SYSTEM			
PERITONEUM	19	19	
CONNECTIVE TISSUE	6	6	
BREAST	297	285	12
VULVA	33	32	1
VAGINA	8	7	1
CERVIX UTERI	37	32	5
CORPUS UTERI	147	144	3
UTERUS			
OVARY	60	59	1
FEMALE GENITAL	6	5	1
PLACENTA			
PENIS			
PROSTATE	169	153	16
TESTIS	10	10	
MALE GENITAL			
KIDNEY	63	56	7
RENAL PELVIS	9	7	2
URETER	5	5	
BLADDER	75	71	4
URINARY ORGANS	3	3	
EYE	5	4	1
MENINGES	22	18	4
BRAIN	22	20	2
CENTRAL NERVOUS SYSTEM	17	16	1
THYROID	45	39	7
ADRENAL GLAND	1		1
ENDOCRINE	15	11	4
LYMPH NODES	35	29	6
UNKNOWN	17	16	1
TOTALS	1785	1648	141

Top Ten All Sites Combined 2010

Male	578	42%
PROSTATE	153	26%
HEAD/NECK	90	16%
LUNG & BRONCHUS	78	13%
URINARY BLADDER	55	10%
COLORECTAL	46	8%
MELANOMA,SKIN	43	8%
KIDNEY & RENAL PELVIS	38	7%
LYMPHOMAS	29	5%
BRAIN/CNS	26	4%
LEUKEMIAS	20	3%

Female	811	58%
BREAST	285	35%
CORPUS UTERI	144	18%
LUNG & BRONCHUS	79	10%
HEAD/NECK	74	9%
OVARY	59	7%
COLORECTAL	59	7%
MELANOMA,SKIN	32	4%
CERVIX UTERI	31	4%
KIDNEY & RENAL PELVIS	25	3%
LYMPHOMAS	23	3%

AJCC Stage & Age at Diagnosis

AJCC Stage at Diagnosis		
Insitu	108	7%
I	555	34%
II	306	18%
III	286	17%
IV	250	15%
NA/UNKNOWN	143	9%

Age at Diagnosis	Male		Female	
10-19	2	<1%	4	<1%
20-29	13	2%	16	2%
30-39	8	1%	56	6%
40-49	36	6%	109	11%
50-59	148	23%	252	25%
60-69	207	32%	255	25%
70-79	142	22%	188	19%
80-89	79	12%	109	11%
90+	11	2%	13	1%

2010 Accomplishments

- ❖ Completed remodel of lower level
- ❖ Hosted physician strategic plan dinner meeting
- ❖ Achieved ACOS Accreditation with Commendation
- ❖ Hosted annual Breast/GYN Symposium
- ❖ Hosted annual Lung/Head & Neck Symposium
- ❖ Hosted patient and professional Neuro-Oncology Symposia
- ❖ Hosted a community cancer screening event with particular attention to the underserved and diverse populations
- ❖ Hosted a statewide Harper's Hope Survivor's Symposium
- ❖ Recruited 500 participants in the I-ELCAP screening program
- ❖ Identified services for possible alignment with Jennie Edmundson Memorial Hospital
- ❖ Monitored PRC patient satisfaction results and created action plans for key drivers
- ❖ Implemented a patient satisfaction tool specific to Harper's Hope services
- ❖ Implemented breast program leadership meetings
- ❖ Implemented an updated pedigree software program (Progeny) for Cancer Prevention and Hereditary Cancer Risk services
- ❖ Initiated regular meetings for the outreach support program for individuals affected by hereditary breast and ovarian cancer
- ❖ Achieved > 7% patient enrollment in clinical research trials of the total number of patients screened
- ❖ Performed Gamma Knife source reload and continued procedure promotion
- ❖ Implemented onsite speech therapy services for Head & Neck Clinic
- ❖ Revised process for distress tool assessment and follow-up

2010 Accomplishments (continued)

- ❖ Increased Breast Care Center diagnostic volumes by 2%
- ❖ Breast Care Center patient satisfaction with overall quality of care maintained above the 95th percentile
- ❖ Adherence to NCCN guidelines for treatment of lung cancer maintained > 90%
- ❖ Explored image enhancement services
- ❖ Finalized agreement with ACS for Hope Lodge
- ❖ Established a Surgical Oncology clinic

2011 MECC Goals

- ❖ Integrate inpatient and outpatient oncology services
- ❖ Facilitate strategic plan dinner meeting
- ❖ Achieve stem cell program accreditation
- ❖ Establish specialty oncology inpatient units
- ❖ Host annual Breast/GYN Symposium
- ❖ Host annual Lung/Head & Neck Symposium
- ❖ Recruit a Thoracic Oncologist
- ❖ Recruit a GYN Oncologist
- ❖ Host community cancer screening events with particular attention to the underserved and diverse populations
- ❖ Host a Harper's Hope Survivorship Symposium
- ❖ Streamline processes to enhance patient flow
- ❖ Publish an annual report
- ❖ Monitor PRC patient satisfaction results and create action plans for key drivers
- ❖ Pursue 100% oncology certification of nurses and allied health professionals
- ❖ Implement the electronic medical record in all hospital-based clinics
- ❖ Streamline processes in the Infusion Center related to patient scheduling to enhance patient and physician satisfaction

2011 Goals (continued)

- ❖ Monitor patient satisfaction specific to Harper's Hope services
- ❖ Provide oncology support services at West Dodge Medical Plaza as needed
- ❖ Expand data collection related to compliance with NCCN guidelines for invasive breast cancer
- ❖ Collaborate with pathology to develop additional molecular pathology tests
- ❖ Achieve > 8% patient enrollment in clinical research trials of the total number of patients screened
- ❖ Pursue American College of Radiation Oncology Accreditation
- ❖ Maintain adherence to NCCN guidelines for treatment of lung cancer > 90%
- ❖ Implement image enhancement services
- ❖ Complete ACS research project
- ❖ Implement PRC patient satisfaction tool for the Infusion Center, Surgical Oncology, GYN Oncology, and Head and Neck Surgical Oncology Clinics
- ❖ Host Nebraska Cancer Summit
- ❖ Add daytime cancer exercise classes to increase exposure of Harper's Hope Wellness Program
- ❖ Utilize videoconference capabilities in Karrer Conference Room to engage referring physicians in outreach communities to participate in treatment planning conferences
- ❖ Establish a medication preauthorization process for the Infusion Center
- ❖ Create survivorship careplans and treatment summaries to comply with 2012 ACOS CoC standards
- ❖ Establish a physician advisory panel for the Lung/Thoracic Oncology Clinic
- ❖ Develop a process to monitor screening of all cancer patients for psychosocial distress
- ❖ Define activities, roles and responsibilities of patient navigation services for oncology
- ❖ Investigate the use of indirect calorimetry for the oncology patient population to assess nutritional needs

2010 Cancer Committee Members

Robert Langdon, MD,
Chairman

Daniel Lydiatt, DDS, MD,
Medical Director, Cancer Center

Josie Abboud,
Methodist Hospital Administration

Amy Bamburg, *Tumor Registry*

Patty Bauer,
Cancer Center Administration

Kim Bland, *Oncology Research*

Margaret Block, MD

Elisa Bomgaars, MD

Laxmi Buddhharaju, MD

Kathy Christiansen,
*Cancer Prevention &
Hereditary Cancer Risk*

Paul Christy, MD

David Crotzer, MD

Randy Duckert, MD

John Edney, MD

Steve Goeser,
Methodist Hospital Administration

Ralph Hauke, MD

David Hilger, MD

Stephen Hosman, MD

Tien-Shew Huang, MD

Peggy Jarrell,
Oncology Social Worker

Brett Jepson, MD

Bev Johnson, *Clinical Effectiveness*

Richard Kutilek, MD

Stephen Lemon, MD

Kristen Leu, MD

William Lydiatt, MD

Fred Massoomi, PharmD

Deb Meyers,
Lung/Thoracic Oncology Clinic

Mary Meysenburg,
Data Management

Oleg Militikhin, MD

Peter Morris, MD

Luke Nordquist, MD

Irina Popa, MD

Diane Randolph,
Home Health and Hospice

James Reilly, MD

Alan Richards, MD

Timothy Richardson, MD

Sharlon Rodgers,
Radiation Oncology

Gordon Scott, *Pastoral Services*

M. Shashidharan, MD

2010 Cancer Committee Members (continued)

William Shiffermiller, MD,
Medical Staff Administration

David Silverberg, MD

Kathryn Simone,
Breast Care Center

Greg Smith, MD

Russell Smith, MD

Yungpo Su, MD

Stefano Tarantolo, MD

Jane Theobald, MD

Stephan Thomé, MD

Teri Tipton,
Nursing Administration

Peter Townley, MD

Nguyet Tran, MD

Eugene Waltke, MD


METHODIST | ESTABROOK CANCER CENTER

The meaning of care. SM

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