Annual Report 2013
### 2012 General Cancer Conferences

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
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<tbody>
<tr>
<td>Number of conferences</td>
<td>22</td>
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<tr>
<td>Number of prospective cases presented</td>
<td>94</td>
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<tr>
<td>Number of cases presented without cancer</td>
<td>1</td>
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<tr>
<td>Total number of cases presented</td>
<td>95</td>
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### 2012 Breast Care Conferences

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<tr>
<td>Number of conferences</td>
<td>25</td>
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<tr>
<td>Number of prospective cases presented</td>
<td>186</td>
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<tr>
<td>Number of cases presented without cancer</td>
<td>16</td>
</tr>
<tr>
<td>Total number of cases presented</td>
<td>202</td>
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### 2012 Thoracic Conferences

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<thead>
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<th>Description</th>
<th>Value</th>
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<tbody>
<tr>
<td>Number of conferences</td>
<td>22</td>
</tr>
<tr>
<td>Number of prospective cases presented</td>
<td>56</td>
</tr>
<tr>
<td>Number of cases presented without cancer</td>
<td>17</td>
</tr>
<tr>
<td>Total number of cases presented</td>
<td>73</td>
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Chairman’s Report

The last year has been one of growth and expansion in the Oncology Program at CMMC. It was also a year for evaluation and assessment. This annual report will highlight some of the services offered and accomplishments of the last year.

The Cancer Program was surveyed in 2013 by the American College of Surgeons Commission on Cancer. The ACoS has defined 35 standards by which to assess the quality of cancer care offered at member institutions. These standards cover areas such as cancer program leadership, tumor registry operation, clinical care, community outreach, research and others. A detailed report is provided to the ACoS regarding the cancer program activities over a three year period, followed by an on-site survey. We are proud to report that the CMMC cancer program was again awarded a three year accreditation. We are proud of this recognition of our high quality, patient focused care.

CMMC also participated in a breast health survey by the National Accreditation Program for Breast Centers (NAPBC) and was granted full accreditation. NAPBC, guided by the American College of Surgeons, sets high standards to ensure quality care is being provided to patients being evaluated and treated for breast cancer. We are very proud of this recognition of the high quality care offered by the Sam and Jennie Bennet Breast Care Center.

In addition to the review of the cancer program as a whole, the medical oncology practice also was reviewed by the American Society of Clinical Oncology. ASCO is the world’s leading professional organization representing physicians who care for patients with cancer. ASCO helps to facilitate a voluntary self-assessment and improvement program for medical oncology practices. The Quality Oncology Practice Initiative (QOPI) is designed to assess compliance with the highest national standards of care. The self assessment process required great commitment of time and resources, but this effort was rewarded with national recognition for the high quality of care provided in the medical oncology department.

Likewise, the radiation oncology program was reviewed by the American College of Radiology. The ACR provides an impartial peer review and evaluation of patient care. Our personnel, equipment, treatment planning and treatment records, as well as patient safety policies and quality control activities were reviewed. Achieving certification from the ACR for the radiation oncology program allows us to demonstrate to our patients, referring physicians and community that CMMC is dedicated to providing the highest quality cancer care.

The care of patients with a cancer diagnosis requires collaborative teamwork among multiple specialists including surgeons, radiologists, pathologists and oncologists. This teamwork and collaboration is enhanced by regular meetings or tumor conferences, where cases are discussed in advance of treatment, and multiple opinions considered. The addition of a dedicated ENT tumor conference in 2013 will only enhance the communication required to provide seamless multi-disciplinary care.

Finally, we would like to recognize the dedication of the staff that makes this high quality care possible. These accomplishments would not be possible without the hard work and commitment of the professionals and staff who work each day caring for our patients.

Nicholette Erickson, M.D.
Following the announcement of the latest CoC guidelines for accreditation of cancer centers, CMMC has continued to expand its Oncology Navigation program in 2013. Building upon services already available for breast and gastro-intestinal cancers, in 2013 we rolled out a navigation program for all thoracic cancer patients.

Oncology Navigation began in Harlem, NY to address socio-cultural barriers to quality oncologic care, and has now been widely adopted by cancer centers nationwide as a tool for patients and providers. Navigation seeks to improve timely access to care for all patients, provide education and support, and help facilitate multidisciplinary communication. In calendar year 2012, Oncology Navigation was provided to approximately 80 GI cancer patients.

The navigator serves as a point of contact for the patient, from the recognition of a suspicious finding through the diagnostic and planning phases, as well as during and after treatment. Navigators coordinate testing schedules, are present for consults with providers, make referrals to support services within the community, and most importantly, are a consistent voice that patients can access directly.
In late 2011, the cancer center established a set of metrics to evaluate the effectiveness of the GI navigation program, leading institutions including the National Cancer Institute and the Association of Community Cancer Centers. We have measured:

1) time from tissue diagnosis to initiation of first treatment course
2) adherence to NCCN guidelines for cancer staging
3) patient satisfaction.

Based on our calendar year data, the GI Oncology navigator helped reduce the time from diagnosis to initiation of treatment from 34.4 in 2011 to 29.8 days in 2012 (fig. A). In 2010, only 39% of colorectal cancer patients had CT scans of their chest before treatment. In 2012, that number has increased to nearly 100% (fig. B). A simple survey was sent out mid-year to patients who worked closely with the GI navigator. The patient response to the program has been quite positive, and we will continue to seek feedback as the program continues.

The oncology navigation program has also been useful in streamlining the pathway from Central Maine Oncology offices, to our partners at Mass General Hospital’s cancer center. The Thoracic Oncology navigator has participated in MGH’s multidisciplinary clinic, works with the MGH access nurse team to coordinate timely referrals, and helps access resources for out of state travel.

Moving forward, the Oncology Navigation program will continue to grow to meet the needs of our healthcare system and our community. We hope to increase the numbers of navigators and navigation sites, and to participate in activities which set high standards for the delivery of these services across the continuum of care.
In May of 2009, a collaborative group of several radiologists and Carmine Frumiento, MD., of Central Maine Vascular Associates at CMMC, joined an international study called the International Early Lung Cancer Action Program (IELCAP). This study was initiated at Cornell University Medical Center by a radiologist, Dr Claudia Henschke in 1992. Patients are enrolled in the study if they are over a certain age and have a significant smoking history. They will then receive two low dose CT scans of the chest at yearly intervals at no charge. These patients will also receive counseling in smoking cessation.

Central Maine Medical Center is one of approximately 70 hospitals in the study and is the only center in Maine performing lung cancer screening. Since opening the trial, we have screened almost 500 patients. Three patients have been found to have lung cancer. Approximately 80 patients were found to have positive findings and are undergoing follow up examinations.

Since its inception, multiple results have been documented. Among these are:

- Curability of State I lung cancer is 80-90%
- Annual CT screening allows at least 80% of lung cancers to be diagnosed at Stage I
- CT screening creates counseling opportunities that result in greater smoking cessation.
- The cost of CT screening for lung cancer compared favorably with breast, cervical and colon cancer screening.

Enrollment for this study is still open. Please contact the research coordinator, Crystal Nayock at 795-5654, with any questions.
## Cancer Incidence Grid

<table>
<thead>
<tr>
<th>SITE</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>% of 2012 Analytic Cases</th>
<th>Estimated 2012 National %</th>
<th>Presented at Ca Conference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>168</td>
<td>154</td>
<td>150</td>
<td>20.4</td>
<td>14</td>
<td>186</td>
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<tr>
<td>Lung / Bronchus</td>
<td>144</td>
<td>138</td>
<td>119</td>
<td>16.2</td>
<td>13.8</td>
<td>43</td>
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<tr>
<td>Prostate</td>
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<td>87</td>
<td>59</td>
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<td>14.8</td>
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<tr>
<td>Colorectal / Anus</td>
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<tr>
<td>SITE</td>
<td>2010</td>
<td>2011</td>
<td>2012</td>
<td>% of 2012 Analytic Cases</td>
<td>Estimated 2012 National %</td>
<td>Presented at Ca Conference</td>
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<td>0</td>
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</table>

**TOTALS**

| Total | 809 | 763 | 735 | 99.8 | 100.2 | 336 |

Brachytherapy is the internal radiation treatment achieved by implanting radioactive material directly into the tumor or very close to it.

Sometimes called internal radiation therapy. Prefix “brachy,” from Greek for “short range.”

Implanting radioactive sources directly into a tumor was a strategy first suggested by Alexander Graham Bell soon after the turn of the century.

**Prostate Brachytherapy**
- Modern technique developed in the 1980’s
- Involves a team of specialists — urologist, radiation oncologist, medical physicist
- Over 100,000 patients treated successfully
- Published studies show results comparable to other forms of definitive therapy
- Iodine 125 with half life of 60 days; low energy

There are two distinct forms of brachytherapy:

1) **Intracavitary irradiation** using radioactive sources that are placed in body cavities in close proximity to the tumor and

2) **Interstitial brachytherapy** using radioactive seeds implanted directly into the tumor volume.
**Permanent Interstitial Implants**

Encapsulated sources with relatively short half-life can be left in place permanently. There are two advantages for the patient:

1) An operation to remove the implant is not needed;
2) the patient can go home with the implant in place.

Iodine-125 has been used most widely to date for permanent implants.

The total prescribed dose is usually about 145 Gy at the periphery of the implanted volume, with 72 Gy delivered in the first half-life of 60 days.

**Prostate Brachytherapy**

**Advantages over standard EBRT:**
- Does not require 8-9 weeks of daily fractionated treatments
- Less long-term toxicity due to radiation of adjacent organs
- Lower incidence of erectile dysfunction
- Day surgery procedure requiring only a single visit

**Disadvantages compared to EBRT:**
- More susceptible to dosimetry errors in delivery of radiation
- Requires a general / spinal anesthetic for implant
- Higher incidence of voiding dysfunction at time and after treatment
- Requires precautions regarding radiation exposure to family and friends
- Only proven for low-stage and low-grade disease (as monotherapy)

The doctor uses the ultrasound images to calculate co-ordinates on a grid-like device (or ‘perineal template’). The perineal template is used to guide the fine hollow needles into the perineum and to ensure that the seeds are placed into the correct position in the prostate.

**NCCN GUIDELINES**

Brachytherapy is a viable option for:
- Very low risk patients with >/= 20 year expected survival
- Low risk patients with >/= 10 year expected survival
- Intermediate risk patients in conjunction with external beam radiation.
- Selected high risk patients with external beam and androgen deprivation therapy

**Monotherapy:** I-125 145Gy
PSA </= 10 ng/ml
Gleason score 2 – 6, selected 7(3+4)
(1 or 2 sextants same side <50% involvement)
T1b – T2a

**Duel-therapy:** EBRT 45Gy with boost I-125 110Gy Stage T2b- T2c
Gleason score 7
PSA > 10 ng/ml < 20 ng/ml

**Exclude:** Severe urinary symptoms ie: IPSS >15
Extensive TURP defect
Substantial median lobe hyperplasia
Prostate dimensions >40 -50cc (selected or downsize) Severe pubic arch interference
Prior pelvic radiation
Inflammatory bowel disease
Life expectancy <5 yrs

**Adverse Effects:** Urinary symptoms common
Dysuria, frequency, urgency, nocturia
Acute urinary retention 1-14%
Urinary incontinence 5- 6%
Proctitis 1-3%

But... Sexual potency preserved 86 -96%
At 2 – 3 years

*NCCN Guidelines Version 2.2013*
A computer program ensures that the right dose of radiation is delivered to the prostate and that other organs (e.g. the rectum) are affected as little as possible by the radioactive seeds.

The number of needles and seeds varies from patient to patient. Usually, between 15 and 25 needles are used to insert between 80 and 120 seeds into the prostate. Once the correct number of seeds have been inserted, the needles are removed. The seeds remain in the prostate permanently, slowing releasing radiation over a period of approximately 9 months (Iodine-125 seeds).

After the procedure, the patient stays in the recovery room for a few hours. X-rays and CT scans are usually then performed. The patient goes home after he has recovered from the anaesthesia. Most patients are able to resume their normal activities within 24–48 hours. Patients usually return for initial follow-up 4–6 weeks after the procedure. Further follow-up visits may occur every 3 months for 1 year and every 6 months for 2 years, and then annually. Prostate-specific antigen (PSA) levels are monitored at all follow-up visits.

Prostate brachytherapy is a highly effective treatment for localized prostate cancer. The efficacy of prostate brachytherapy monotherapy in patients with low- to intermediate-risk disease has been demonstrated in numerous clinical studies. In the study by Khaksar and colleagues, patients were assessed for a period of 5 years after treatment with prostate brachytherapy.\(^1\) After 5 years, 93% of patients had not experienced a relapse in disease (assessed by measurement of PSA levels). In other studies of prostate brachytherapy with follow-up periods between 8 and 13 years, PSA relapse-free survival was again high, ranging from 72–87%.\(^2\)–\(^6\)

Prostate brachytherapy has been shown to be as effective as the other radical treatment options for localised prostate cancer (prostatectomy and EBRT). In the study of Kupelian and colleagues, patients were monitored for several years after they had been treated with either prostate brachytherapy, EBRT U 72 Gy, radical prostatectomy, or a combination of prostate brachytherapy and EBRT.\(^7\) PSA relapse-free survival was very similar in all patients, whether they had received prostate brachytherapy or one of the other treatments.

All treatment decisions are based on the balance between potential benefits and risks. Overall, there are many potential advantages associated with prostate brachytherapy. Importantly, patients treated with brachytherapy are more likely to retain their quality of life, compared with patients treated with other forms of therapy. Prostate brachytherapy may be particularly suitable for sexually active men concerned about retaining potency.

Although the radioactive seeds used during prostate brachytherapy are not dangerous, it is recommended that men avoid prolonged physical contact with small children or pregnant women for 2 months after treatment.
Survival Study 2011 Annual Report (at least 5 yr f/u):

- 249 low risk and early intermediate pts whose date of diagnosis ranged from January 2000-December 2004
- Consultation discussed NCCN guideline recommendations with patients accepting brachytherapy as treatment of choice
- Date of implant May 2000-2006
- offered to patients age 65 or older unless they refused surgery or were medically inoperable (at least 5-10 yr life expectancy)
- age ranged from 48-84 yrs
- IPSS 15 or less
- adjuvant deprivation therapy used to downsize the gland to prepare for seed implant or had been placed on hormones by the referring urologist
- duration of ADT ranged from 3 months-3 years
- 60% of patients were started on ADT prior to consultation in RadOnc
- 175 or 70% of patients received ADT in that 5 yr eval so data is skewed

CMMC 5 yr survival data

- Date of last contact ranged from Nov 2001 –June 2010
- 5 yr data f/u was from date of diagnosis
- Findings:
  - 40 pts died- 16% total
  - 2 died of metastatic prostate cancer 0.8%
  - 38 DOC and PSA <= 1.0
  - overall survival rate 84%
  - overall biochemical DFS 99%

CMMC 1999-2012

Implant alone 145 Gy: 367 patients
External beam 45Gy +110 Gy: 93 patients
ADT: 323 pts

CMMC –Monotx 1999-2011

- 137 pts I-125 (no ADT; no boost)
- Age: 47-81 y.o.; Average: 67 y.o.
- T1c-89 pts; T2a -45 pts; T2b-3 pts
- PSA <= 10.0
- IPSS <15 with exception 3 pts
- Gleason 5-6 : 123 pts; Gleason 7(3+4) : 13 pts
- Gleason 7 (4+3): 1 pt ( refused ADT or IMRT) PSA=11.0

Monotherapy 1999-2011

- Follow up ranged from 1-11 years
- 1 pt lost to follow-up at 2 years out
- Failure = rising PSA not c/w benign PSA spike
- Failures: 7 failures overall; 5.1 % failure rate
  - 1 Bone metastases
  - 1 Watch
  - 3 Rising PSA’s on ADT no mets
  - 1 Died of Metastatic Prostate Cancer (gl 7 T2b)
  - 1 Died of Other Disease
  - Review of Dosimetry performed: good implant quality

Urinary Symptoms

- All patients treated with Alpha blockade after implant
- 115 pts back to baseline IPSS scores at 1 year 84%
- 22 pts : uretheral stricture 3 pts 2%; TURP 4 pts 2.9%

Bowel Symptoms

- 1 pt Rectoprostatic Fistula –diverting colostomy now reversed and doing well
- 8 pts proctitis requiring Argon laser therapy 5.8%
- 5 pts with diarrhea 6 months following implant

Sexual Function

- Difficult to determine as many patients were impotent prior to the implant
- Appears: patients who had full function retained function at 5 years
- Patients who had poor function +/- drugs were impotent at 2-3 years after implant

Monotherapy 1999-2011 Results

- Failure rate: 5.1%
- Control Rate: 94.9% f/u 1-12 years
- One patient DOD
- 18 Died of other causes

Summary | 125 Implant:

- An alternative to other recommended radical treatments for localized prostate cancer
- Involves the transperineal placement of radioactive seeds directly into the prostate
- As effective as other recommended radical treatments at curing cancer and prolonging patient survival

References

1 Khaksar et al. BJU Int 2006; 98: 1210–5.
In 2013, The Patrick Dempsey Center for Cancer Hope & Healing celebrated its fifth year of providing free support, education and integrative medicine services to cancer patients, survivors and their families. The Center was founded by actor and Maine native Patrick Dempsey in response to his mother’s multiple bouts with ovarian cancer.

Over the past year, the Center has:
- Expanded massage services to all cancer patients
- Added evening hours and appointments
- Provided educational cooking classes
- Added one-on-one nutrition consultations
- Expanded the Wellness for Life program
- Increased integrative medicine service appointments
- Increased the number of staff oncology social workers
- Enhanced the lending library to include more resources and a pair of computer stations
- Expanded youth and family program offerings including yoga and cooking classes
- Added a Women’s Cancer Support Group and a Tobacco Support Group
The continued growth enables the Center to serve and meet the needs of people in this community and beyond. The Center’s new space at 29 Lowell Street (opened in September, 2012) provides a comfortable, healing environment for our patients and their families as they face one of the most difficult challenges of their lives.

The Center will continue to expand its services, education and programs, all of which are available at no cost to anyone impacted by cancer, thanks to the continued support of participants, donors, sponsors, volunteers and its primary fundraiser, The Dempsey Challenge. It is because of this support that the Center has grown from 1,200 contacts in 2009 to over 15,000 in 2012. While we do not yet have the final number of contacts for calendar year 2013, we expect to exceed our 2012 total.

The Dempsey Challenge, which also celebrated its fifth year, raised over $1.13 million for the Dempsey Center in 2013, drawing 3,801 participants from 37 states and eight countries. Over the past five years, the Dempsey Challenge has raised more than $5 million to benefit the Dempsey Center.

“Five years ago this event was just an idea, but it is this community that made it a reality. The Dempsey Challenge is not the product of one vision, but of a collective effort to build hope, improve lives and show support. It’s a beautiful thing, and I’m so proud to be a part of it.”

—Patrick Dempsey
Founder, The Patrick Dempsey Center for Cancer Hope & Healing
The Dempsey Challenge

Two Dempsey Center volunteers were awarded with The Maine Governors Award for Service and Volunteerism. The award is given to volunteers with at least 500 hours of service in one year. Richard Lavoie (left) and Phyllis Benoit (right) were presented the award by Mary Dempsey.
The resources of one of the world’s top cancer program are now available to patients being treated at Central Maine Healthcare hospitals and Parkview Adventist Medical Center.

Central Maine Healthcare (CMH) and the Massachusetts General Hospital (MGH) have developed a collaborative program that is already connecting patients from central, western and mid coast Maine to cancer care subspecialists in Boston.

CMH Cancer Center announced their “Working with Massachusetts General Hospital” Cancer Center at a press conference on May 23, 2013 with Dr. Karen Ballen, MGH Cancer Center and Dr. Nicholette Erickson, CMH Cancer Center. This partnership will provide patients with community-based cancer care and access to the expertise of world-renowned cancer subspecialists from the Mass General Cancer Center in Boston.

“Central Maine Medical Center has an excellent cancer care program. We provide medical, surgical and radiation oncology, supportive services at The Patrick Dempsey Center for Cancer Hope and Healing and support a dedicated breast care center.” said CMH President and CEO Peter E. Chalke.

“However,” he added, “when a patient requires services of a top academic cancer center, the Mass General connection allows us to quickly and effectively get care for these patients at a world renowned cancer program. The system is so well organized that patients needing this additional level of care are astonished at how quickly and seamlessly it can be delivered.”
David Ryan, M.D., Clinical Director at the MGH Cancer Center and chief of Hematology-Oncology at MGH, said, “Mass General is committed to providing everyone in New England access to the best care and technology. The world of cancer medicine is rapidly changing and our relationship with Central Maine Healthcare allows for their patients to have access to the best possible outcomes when it comes to cancer treatments.”

MGH Cancer Center is an integral part of the CMH Cancer Center, providing patients with immediate access to highly specialized oncology experts and 23 fully integrated, multidisciplinary clinical cancer programs, not available in Maine. The collaboration consists of frequent communication with MGH and CMH Cancer Center senior administration, monthly genetic counseling services in Lewiston, monthly Cancer Conferences in Lewiston with MGH sub specialists, clinical access nurse referral services as well as educational conferences.

To date over 130 patients have been referred to MGH CANCER CENTER WITH 90% more than 90% able to receive their CANCER CARE IN CENTRAL MAINE.
For most cancer patients, CMH can provide the required diagnostic and treatment services. However, a small number of patients require care not available locally. The CMH oncologists communicate regularly with specialists at MGH when sharing patients to provide seamless care at both locations.

**MGH CANCER CENTER**

*offers patients access to*

- of promising new therapies not available in Maine or elsewhere.

Patients also benefit from genetic testing and counseling services in Lewiston and from expanded access to clinical trials.

The MGH Center for Cancer Risk Assessment conducts a monthly clinic in Lewiston. The clinic, conducted by Kristin Shannon, MS, CGS, provides genetic testing, counseling and support for individuals and families at risk for hereditary cancer. This includes key programs in breast, ovarian, gastrointestinal, renal and endocrine cancers.

Our commitment to eradicating cancer is fueled by scientific investigation as part of the largest hospital-based research program in the United States. Integrating compassionate care with leading-edge research ensures that each patient receives the best possible personalized cancer medicine.
Cancer Committee Membership

Nicholette Erickson, MD, Chair
Greg D’Augustine, MD, Liaison
David Caldwell, MD, Medical Oncologist
Courtney Jensen, MD, Radiation Oncologist
Paul Mailhot, MD, Surgeon
Sue Mandell, MD, Radiation Oncologist
Daniel Rausch, MD, Medical Oncologist
Susan Schraft, MD, Radiologist
John Skinner, M,D Pathologist
Terry Baker, ACS
Samantha Brooks, CTR
Douglas DiVello, FACHE
Jackie Fournier, NP, Pallative Care
Maureen Higgins, Coordinator Outreach
Barbara Matarazzo, CTR
Diane Mulkhey, RTT
Patty Roy, RN, MSN, CPHQ
Kathy Sonagere, PT
Wendy Tardif, Dempsey Center
Sherri Turcotte, RN
Kathi Varney, NP, Bennett Breast Center
Kathleen Vieira, RN