2012 CANCER ANNUAL REPORT

Charles L. and Rose Sweeney
Meloneyzer Pavilion
and Regional Cancer Center

MVH HEALTHCARE
Cancer Care Team

Cover photo — Radiation Therapy Team (left to right): Radiation Therapist Marcie Moessner, R.T. (R) (T); Director of Radiation Oncology Debbie Burkhardt, R.T. (R) (T) (CT); Radiation Oncology Nurse Michele Haffman, RN, OCN; Medical Director of Radiation Oncology Mohsen A. Isaac, M.D.; Radiation Oncologist Victor G. Onufrey, M.D.; Medical Physicist and MVH Radiation Safety Officer Michael Semon; and Radiation Therapist Christopher Sagosky.

In the photos above, top row left to right — Outpatient Medical Oncology includes: Kathy Forsyth, RN; Nurse Manager Denise Thorn, RN; Phlebotomist Angie Scott; Carol Manown, RN; Jessica Fitch, RN; Rosemary Stankovich, RN; Anne Raible, RN; Alexis Sanner, RN; and Keisha Jones, Medical Assistant.

7th Floor Inpatient Oncology Unit (left to right): Seated are Cynthia Geletei, NA, and Nurse Manager of Inpatient Oncology Amie Matyas, RN, OCN. Standing from left are Maryann Dudas, RN; Meagan Layman, NA; Unit Clerk Debra Kerekes, Cheryl Young, NA; Heather Hart, L.S.W.; Krista Begonia, RD; Ashley Monack, RN; and Kathleen Ambrose, RN.

Lymphedema Therapists (left to right): Cindi Patterson, Physical Therapy; Christa Tang, Rehabilitation Supervisor.

Bottom row, left to right — Medical Oncology Services (left to right): Giridhar A. Santebennur, M.D.; Nabil E. Zaglama, M.D.; Lori Lasich, CRNP, Andrew J. Zahalsky, M.D.; and Dawson Lim, M.D.

Radiation Oncology Physicians (left to right): Victor G. Onufrey, M.D.; Judith H. Figura, M.D.; Mohsen A. Isaac, M.D.; and Hung-Chi Ho, M.D.

A Stereotactic Mammography procedure

At right — a promotional flier for a Prostate Cancer Support Group meeting at Monongahela Valley Hospital.

Prostate Cancer Support Group

Accepting that you have cancer is hard. You and those close to you may feel scared, angry or sad — all normal feelings. You’re not alone and we can help.

We can help you with:
- Support from others with prostate cancer
- Practical skills to help you cope
- Reliable information
- Tips on how to talk with your caregivers about your feelings

Wednesday, November 14 at 6 p.m.
Anthony M. Lombardi Education Conference Center, Monongahela Valley Hospital

Attendance is free but registration is requested by calling 724-292-9404.
Message From The Chairman

Andrew J. Zahalsky, M.D.
Chairman
Oncology Committee

As Director of Medical Oncology at Monongahela Valley Hospital and Chairman of the Oncology Committee, it is my privilege to invite you to review our 2012 Cancer Program’s Annual Report.

The Oncology Committee of Monongahela Valley Hospital is a multidisciplinary committee of physicians and support staff that is entrusted with overseeing the many activities of our Vision of Hope Cancer Care Program. You will see many of their faces on the cover and on the opposite page.

Each year, we look back at the progress made in the previous year and set goals for the future. Please note that this 2012 Cancer Program Annual Report will discuss the progress we made in 2011. In addition, each annual report summarizes our ongoing efforts to improve our programs and contains a statement of our goals for the continuing advances both this year and next.

During calendar year 2011, Monongahela Valley Hospital continued to upgrade its equipment, facilities and staffing arrangements to ensure that we are providing state-of-the-art cancer care in a high-quality setting.

In April 2011, Monongahela Valley Hospital broke ground for the largest expansion and construction project since the hospital was built in the late 1970s. This expansion affects us directly as it will enable us to add a $3 million linear accelerator to our Regional Cancer Center. The new “Lin ace” will provide image guided radiation therapy (IGRT) that gives unparalleled precision and accuracy in treating tumors and preserving healthy tissue. The hospital will also add four new state-of-the-art surgical suites and other improvements that will benefit our patients. In 2011, MVH also began administering high-dose radiation implants in a process known as brachytherapy, which treats cancer from the inside out. High doses of radiation are implanted close to or inside the tumors or cancerous tissues, minimizing exposure to healthy tissue and reducing treatment times.

These improvements have not gone unnoticed. The Vision of Hope Cancer Care Program at Monongahela Valley Hospital is reviewed once every three years by the Commission on Cancer of the American College of Surgeons. Based on our activities from 2009-2011, our program was reaccredited as a Community Hospital Cancer Program.

The Vision of Hope Cancer Care Program also carried out many projects in 2011 designed to limit the impact of cancer in our community through prevention, education, and early detection. Community screening and educational activities included screening days for breast cancer, colon cancer and prostate cancer. Nearly 300 people participated in our screening programs throughout the year. Other patient-centered programs included a general cancer support group and a disease-specific breast cancer support group, both of which met monthly. Our prostate cancer support group meets four times each year. While attendance at the meetings varies from overwhelming to smaller and more intimate, we work hard with our Hospital’s marketing team to promote our free support group meetings to the community in multiple ways, including reaching out in senior living facilities, gyms and libraries; free and paid messages in newspapers, magazines and online; through physicians and community programs; alerts on the Internet and even on our Hospital’s Facebook page.

In addition to providing programs to the community, the Vision of Hope Cancer Care Program also collects and analyzes data on the patients treated at Monongahela Valley Hospital in the hopes of finding trends and patterns which can then be used to further improve the care we provide. Included in this 2012 Cancer Program Annual Report is an analysis of some of the data collected by our Tumor Registry. As you will see, the focus of this year’s report is prostate cancer.

Prostate cancer is the most common cancer in American men, other than skin cancer, and primarily affects older men. The average age at the time of diagnosis is about 67 and it is rarely seen before age 40, according to the American Cancer Society. Prostate cancer is also the second leading cause of cancer death in American men, after lung cancer. The most recent statistics available say that 1 in 36 men will die of prostate cancer.

The latest American Cancer Society estimates for prostate cancer in the United States for 2012 tell us that more than 241,000 new cases of prostate cancer will be diagnosed and about 28,000 men will die of prostate cancer. About 1 man in 6 will be diagnosed with prostate cancer during his lifetime.

At Monongahela Valley Hospital, prostate cancer is the most common type of cancer that we treat in men.

As always, I would like to say how honored I am to work with the staff of Monongahela Valley Hospital toward the goal of providing convenient, high-quality, and compassionate oncology services to the communities of the Mid-Monongahela Valley. But most of all, I would like to thank all of the patients and their families for allowing us into their lives and for touching my own.

Andrew J. Zahalsky, M.D.
Chairman
Oncology Committee

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Oncology Committee

MVH Vision of Hope Cancer Care
**Primary Sites - 2011**

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**TOTAL**

190 | 194 | 384

This report includes carcinoma in-situ cervix cases, squamous and basal cell skin cases, and intraepithelial neoplasia cases.
Prostate cancer is the most common cancer in men with more than 241,000 new cases being diagnosed in the United States in 2012. Frequently, prostate cancer is a slow growing disease which is responsive to several forms of treatment. Therefore, the majority of men with prostate cancer do not die of this disease. However, prostate cancer does have the ability to turn more aggressive, and approximately 28,000 men in the United States will lose their lives to prostate cancer this year.

**RISK FACTORS**

Since the prostate gland is a component of only the male genitourinary system and does not exist in women, the biggest risk factor for the development of prostate cancer is being male. In men, the biggest risk factor for the development of prostate cancer is advancing age. The older a man gets, the more likely he is to develop an abnormality within the prostate. Fortunately, the older a man is when he is diagnosed with prostate cancer, the more likely it is that his disease will behave less aggressively. In fact, if men are diagnosed with prostate cancer when they are older than age 70, it is more likely that the prostate cancer will not be the ultimate cause of death because of the slow growing nature of prostate cancer in elderly men.

There is a genetic component to prostate cancer risk. There is an approximately 1.5 times higher risk of developing prostate cancer if a first-degree relative (father, brother, or son) has had prostate cancer than if no relatives have had prostate cancer. It does not appear that sexual activity has a relationship to the development of prostate cancer. There is no data to suggest that either refraining from sexual activity or engaging in excessive sexual activity will alter a patient’s risk for the development of prostate cancer.

**DIAGNOSTIC TESTS**

Prostate specific antigen, or PSA, is a protein that is only produced by prostate cells. Laboratory testing can measure the level of PSA in a man’s blood. Since prostate cancer is an abnormal growth of the prostate, the prostate cancer cells may produce an abnormally high level of PSA. It is important to note that benign (not cancerous) conditions which cause enlargement of the prostate, such as Benign Prostatic Hyper trophy (BPH) or inflammatory conditions in the prostate, such as prostatitis, can also cause an elevation of the PSA. Therefore, an elevated PSA is useful as a screening test and can suggest that there may be a problem with the prostate. However, an elevated PSA by itself is not conclusively diagnostic of prostate cancer. Sometimes, measuring the ratio of free PSA vs. protein bound PSA can further clarify the significance of an elevated PSA reading. It is also important to note that not every prostate cancer will make extra PSA protein. Therefore, a normal PSA value does not completely rule out the possibility of having prostate cancer.

As a supplement to the PSA test, a rectal examination is also important in evaluating men for prostate cancer. The prostate is positioned at the base of the bladder immediately in front of the rectum. Therefore, if a doctor inserts a gloved finger into the rectum and pushes on the front wall of the rectum, the doctor can feel the prostate and detect prostatic enlargement or abnormal lumps within the prostate.

If an abnormality is detected, the next test is usually a biopsy. A small needle is inserted into the back of the prostate through the front wall of the rectum. Sometimes, an ultrasound is also performed to help guide where the needle should be inserted. A small piece of prostate tissue is removed by the needle and reviewed under the microscope. When a pathologist looks at the tissue, he or she can tell if it is cancerous, and if so, how aggressive the cancer appears to be.
Once a cancer is diagnosed, additional tests are performed to determine if, and how far, the cancer has spread. A CT scan or an MRI of the abdomen and pelvis will look for any direct extension of the cancer out of the prostate gland itself and can also determine if it has spread to the surrounding pelvic lymph nodes. When prostate cancer does spread, it often goes to the bones. Therefore, a bone scan is usually performed to look for bony involvement.

Once it has been determined how advanced the cancer is, a treatment plan will be recommended. Blood tests and sometimes testing of the heart may also be necessary to make sure a patient can tolerate the recommended treatment.

### STAGING

Prostate cancer staging is an expression of how large the cancer is at diagnosis and the extent to which it has spread within the body. There are three components to the Staging Code. These are T – for tumor size, N – for the degree of lymph node involvement, and M – for metastatic status. These three elements are then combined to give an overall stage, numbered I-IV.

Stage I and Stage II cancers are completely contained within the prostate without any spread to the local lymph nodes or to the rest of the body. Stage III cancers have spread through the wall of the prostate into the surrounding area, but are still confined to the area around the prostate. Stage IV means there is more advanced spread of the cancer, which can include either local invasion of other organs near the prostate, spread into the pelvic lymph nodes, or spread to other parts of the body (called a metastasis).

For prostate cancer, another important piece of information is the Gleason Score. The Gleason Score is a number between 2 and 10 which signifies microscopic findings that tell the pathologist how aggressively the cancer appears to be growing. Lower numbers indicate that the cancer appears to be slower growing and less likely to spread.

### TREATMENT

Treatment of prostate cancer falls into five major categories: surgery, radiation, hormonal therapy, chemotherapy, and immunologic therapy. Surgery is a procedure to remove the cancer from the body. Radiation uses X-ray beams to try to burn cancer cells and kill them without physically removing them. Both surgery and radiation are considered local therapy – the cancer is only eliminated where a cut is made or where the beam of x-rays is focused.

Hormonal therapy is medication, given either as an injection or in pill form, which circulating throughout the body and attempts to starve the cancer cells of testosterone. Since many prostate cancers need the male hormone testosterone to grow, hormonal therapy can successfully kill prostate cancer cells wherever they are hiding. Chemotherapy also means the administration...
of medications which can circulate in the blood stream and kill prostate cancer cells anywhere in the body. However, the medications used for chemotherapy try to poison the cancer cells rather than starve them of testosterone. Immunologic Therapy is a method to train a patient’s own immune cells to seek out and attack the cancerous cells, hopefully without damaging the non-cancerous cells in the body.

Surgical removal of the prostate is usually recommended for young men with prostate cancer that remains localized to the prostate. Since older men tend to have other medical problems that could make surgery more risky, older men are usually offered radiation therapy, even if the disease remains localized. Sometimes hormonal therapy can be combined with local radiation therapy to make the radiation more effective. Monongahela Valley Hospital uses the most advanced form of radiation therapy, called Image Guided Radiation Therapy, or IGRT, to maximize the treatment of patients with prostate cancer while minimizing the side effects on the surrounding normal tissues. With IGRT, an ultrasound is used prior to each treatment to assess the position of internal organs near the prostate, such as the bladder, so that the radiation beams can be targeted specifically against the cancer while avoiding normal tissue.

When the disease has already spread outside of the prostate, the first line of attack is usually hormonal therapy. Radiation therapy is sometimes added to a particular area if that area needs extra attention, for example if a metastasis in a bone is painful. Chemotherapy is usually reserved for those patients in whom hormonal therapy is no longer working. The role of immunologic therapy in prostate cancer is still limited. Immunologic therapy can slightly prolong the life of men suffering from prostate cancer, but is only FDA approved to be given to asymptomatic men whose cancer has returned after initial local therapy but whose recurrent cancer has not grown large enough to cause any symptoms.

**LOCAL PATTERNS OF DISEASE**

This year, the Oncology Committee of Monongahela Valley Hospital decided to review our Tumor Registry data for patients who were diagnosed with prostate cancer in 2011. We have also compared this information to data from our Hospital from the four prior years (2007-2010) as well as to available data from the American College of Surgeons’ National Cancer Data Base (NCDB).

Figure #1 shows the distribution of prostate cancer cases by stage at the time of diagnosis for each of the last five years. In all years, the majority of prostate cancers were diagnosed at early stages, either Stage I or Stage II, with the plurality of cases being Stage II for each year. These early stage cancers are the easi-
Prostate Cancer Summary Report (cont.)

It is estimated that 90% of prostate cancer is treatable and carries an excellent prognosis. Monongahela Valley Hospital staff is well aware of the importance of early detection for improving the survival rate of prostate cancer patients. We host an annual Prostate Cancer Education and Screening Program in order to screen at-risk men and help to diagnose any cancers when they are in the earliest stages.

Figure #2 compares the cumulative five-year data from Monongahela Valley Hospital with four-year (2007-2010) nationwide data from the NCDB. Although we had a slightly higher level of Stage I patients and a corresponding lower level of Stage II patients, overall, it appears that the Monongahela Valley Hospital data parallels the national data, with the vast majority of patients being diagnosed at an early stage in their disease and the minority of patients being diagnosed at Stage III or Stage IV.

Figure #3 shows the distribution of prostate cancer cases by the age of the patient at the time of diagnosis for each of the last five years. As expected, the data shows that prostate cancer is a disease of older men. In 2007, 2008, and 2009, 50 percent or more of the patients were age 70 or older at diagnosis. In 2010 and 2011, the majority of patients were age 60 or older. Relatively few cases of prostate cancer are found in men age 59 or younger.

Figure #4 compares the local data to the NCDB national data. On a national level, more patients fall into the 40-49, 50-59, and 60-69 age groups, while fewer patients fall in the 70-79 and 80+ age groups. The population of prostate cancer patients at Monongahela Valley Hospital is older than the general population, reflective of the large elderly population in the communities served by our hospital.

In order to evaluate long-term survival trends in prostate cancer, we looked back at the five-year...
survival data from the cohort of patients diagnosed in 2007. Figure #5 summarizes the survival data. Overall survival analysis of all patients with prostate cancer diagnosed in 2007 shows that the majority of patients (65 percent) live longer than five years, again demonstrating that prostate cancer is a treatable cancer and not a death sentence. Given that the majority of patients diagnosed with prostate cancer were older than 70 years of age, and that elderly patients frequently have additional medical problems which may have been the actual cause of death, the percentage of men who actually died from their prostate cancer is actually lower than the 35 percent that the data implies. Figure #5 also breaks out the survival data by the stage at diagnosis. All of the Stage I and Stage III patients diagnosed in 2007 are still alive. The curve for Stage II patients closely follows the curve for all patients, representing the fact that the majority of patients were Stage II at diagnosis, so that group makes up the bulk of the overall data as well. Patients with more advanced, Stage IV disease did worse than the earlier stage patients. The patients with “Unknown Stage” also did worse, but this could be because those patients had other medical issues which took priority, such that they were never able to undergo a full staging work-up.

In summary, prostate cancer is a common cancer both at Monongahela Valley Hospital and across the nation. Early detection leads to easier treatment and improved survival, emphasizing the need for regular screening. Treatment options are available, even for patients with more advanced disease and for older patients. Monongahela Valley Hospital continues in its efforts to provide the best available care for all of its cancer patients and for the community we serve.
A Cancer Registry is a data management system in which valuable information is collected, organized and analyzed on patients who are diagnosed with cancer. The Cancer Registry at Monongahela Valley Hospital plays an important role by providing a multitude of services and support to all aspects of the cancer program.

Registry data is used to determine the number of newly diagnosed cancer cases in a given year. Registry data is also used to document treatment information on specific types of malignancies, and to gather information for studies, audits and research. The registry also provides site-specific data in conjunction with cases presented at the weekly Tumor Board Conferences.

The Cancer Registry at Monongahela Valley Hospital was established in 1990 under the supervision of the Oncology Committee and the Medical Records Department. In 2011, 452 cases were added to this database. This brings the total number of patients accessioned to greater than 10,550, with the caveat that since 2003, patients with more than one cancer are now counted only once instead of once for each cancer. At least 2,596 of the patients documented in the database continue to survive, although it should be noted that surviving patients are excluded from the registry when they reach age 100.

The Tumor Registrar submits data to the Pennsylvania Cancer Registry, in addition to the National Cancer Database, allowing Monongahela Valley Hospital to benchmark its data against other hospitals. Since its inception, the Monongahela Valley Hospital Cancer Registry has received recognition for its excellence in data quality, data accuracy, and completion of case finding.

During 2011, Monongahela Valley Hospital’s Cancer Registry participated in the National Cancer Data Base’s Annual Call for Data and submitted data from 1998 to 2009.

The Cancer Registry staff conducts a wide range of technical duties, including continued medical surveillance to provide outcome data. The status of each cancer patient is monitored through lifetime follow-up. Monongahela Valley Hospital’s Cancer Registry maintains a successful follow-up rate on all analytic patients in accordance with the guidelines of the Commission on Cancer.

The Cancer Registrar maintains active membership in the National and State Tumor Registrar Associations. Continuing education is provided to the registry staff on an ongoing basis. The staff has attended local as well as offsite seminars in efforts to keep abreast of ongoing changes in cancer data management.

The Cancer Registrar also serves as a field instructor to health information management students via the externship program at the University of Pittsburgh.

2012 Cancer Registry Goals:

1. Submit abstracts within the required timeframe of 180 days
2. Submit information to the National Cancer Data Base without errors
3. Maintain its excellence in data quality and follow-up rates in the Vision of Hope Cancer Care Program at Monongahela Valley Hospital
4. Become proficient in abstracting cases using the new AJCC 7th edition of the staging system and the revised collaborative staging criteria
Vision of Hope Reflections

The Oncology staff continues to improve care through education.

Our staff participated in many educational opportunities in 2011. The 2011 oncology nursing staff journal club included 24 topics in oncology nursing with topics chosen based on case mix, symptom management, psychosocial, safety and best practice applications. Staff also participated in the weekly multidisciplinary tumor board conferences. Staff is committed to remaining current with emerging treatment and management for the care and service of our oncology patients and their families. Nine registered nurses received certification in chemotherapy administration. The classes are sponsored by the Oncology Nursing Society and provide staff with updates in chemotherapy/biotherapy administration and current treatment plans. Amie Matyas, RN, OCN, became certified as an ONS chemotherapy/biotherapy instructor and presented her first class at MVH in November 2011.

The team also created an Oncology Symposium that will serve as an annual update on cancer treatment, bringing together several experts in medical, radiation, and surgical oncology to discuss new research and treatment. Thirty one (31) attended as the 2011 speakers discussed lung cancer, head and neck cancer, mantle cell lymphoma and the complicated emotions of grieving.

Community Programs are a vital part of the Oncology Program and included:

The Breast Cancer Support and Cancer Support groups facilitated by Nurse Manager Amie Matyas, RN, OCN, continue to meet monthly at MVH. The Prostate Cancer Support Group continues to meet quarterly.

MVH participated in the American Cancer Society Daffodil Days and distributed daffodils on March 16, 2011, to all patients and visitors entering the hospital. The event raised $3,000 for the American Cancer Society, $200 more than the previous year.

A Colorectal Cancer Education and Screening Program was held at MVH on April 27, 2011, with 24 attendees. Andrew J. Zahalsky, M.D.; John R. Hauser, M.D.; Nurse Manager of the Inpatient Oncology Unit Amie Matyas, RN, OCN, and Clinical Dietitian Krista Begonia presented. Participants were given take-home colorectal screening kits. No participants had abnormal results and all results were sent to the participants’ Primary Care Physicians.

On May 11, 2011, MVH’s walk-in health care facility Healthy Directions at Giant Eagle, held a free Skin Cancer Screening with Dr. Paul Ruschak, M.D. Of the 57 participants, two (2) abnormal results were noted and patients were recommended to have a biopsy.

Amie Matyas RN, OCN, represented MVH as the team captain for the Relay for Life Annual Celebration for cancer survivors on June 18, 2011. The staff of MVH supported the event with $1,000 to honor all of the hospital’s survivors. The team raised $2,184 to support the American Cancer Society.

MVH held the Community Program “Look Good... Feel Better” on July 23, 2011. Sponsored by the American Cancer Society, this program assists women undergoing treatment for cancer. Cosmetologists gave helpful advice on skin and hair treatment. Each participant received a makeup kit.

During Prostate Cancer Awareness Month, Andrew J. Zahalsky, M.D., presented an education and screening program on Sept. 28, 2011, to an audience of 70 people. Of those, 63 participated in the screening provided by medical staff and SameDay Surgery nursing staff. Six participants had abnormal lab results, and were referred to their Primary Care Physicians for follow-up.

The Radiation Oncology department began performing brachytherapy in October using High Dose Radiation (HDR). Brachytherapy plays a key role in the treatment of breast cancers with a treatment technique called accelerated partial-breast irradiation. This allows for certain patients to be treated in only one week instead of the conventional six weeks required with external beam irradiation. HDR can also be used for cancer treatments of the lung, esophageal and various gynecological tumors. Also in 2011, Medical Director of Radiation Oncology Mohsen Isaac, M.D., presented research data on Iodine-125 seed therapy at a HDR conference held in San Francisco, Calif. The department also began its intra-operative radiation seed implantation program for lung cancer. This treatment technique is a surgical procedure done at the time of a partial lung resection where the thoracic surgeon and radiation oncologist implant radiation seeds at the lung resection site.

Led by MVH’s Chief Radiation Therapist Debbie Burkhardt, MVH staff participated in the annual Lois Orange Ducoeur Breast Cancer Awareness Walk on Oct. 8, 2011. This event helps provide quality care, comfort and hope to local cancer patients using the Charles L. and Rose Sweeney Melenyzer Pavilion and Regional Cancer Center at MVH.

On Oct. 26, 2011, MVH hosted a Breast Cancer Education and Screening Luncheon for 64 women. Speakers included Andrew J. Zahalsky, M.D., Natalie Furguiele-Iracki, M.D., and Mohsen Isaac, M.D. Twenty-one (21) participants completed the free breast cancer screening exam performed by medical staff. All results were sent to participants’ Primary Care Physicians. Eight participants received mammography prescriptions and scheduled their mammograms that day.

Provision of services for patients with lymphedema and vascular disease by the Physical Therapy staff included continuation of lower extremity treatment in the Center for Wound Management and upper extremity treatment in the Physical Therapy Department. Referrals for upper extremity lymphedema totaled 13. All treatments had a diagnosis of breast cancer. Certified staff from the Physical Therapy Department was available for questions at the Breast Cancer Education and Screening luncheon.
Monongahela Valley Hospital
Oncology Committee

Andrew J. Zahalsky, M.D.
   Committee Chairman,
   Medical Oncology
Abdul Chaudry, M.D.
   Radiology
Paul N. Cervone, M.D.
   Gynecology
Marc E. Cordero, M.D.
   General Surgery
Marie Faraci, M.D.
   Obstetrics/Gynecology
Natalie Furgiuele-Iracki, M.D.
   General Surgery/Breast Cancer Specialty
David O. Hepps, M.D.
   Urology
Mohsen A. Isaac, M.D.
   Radiation Therapy
Nirmal Kotwal, M.D.
   Pathology
R.G. Krishnan, M.D.
   President, Medical Staff
Dawson Lim, M.D.
   Medical Oncology
Vasu N. Malepati, M.D.
   Otorhinolaryngology
Mandiga Rao, M.D.
   Anesthesiology & Pain Management
Ashok K. Sahai, M.D.
   General Surgery
Ramya Sahasranamam, M.D.
   Nephrology
Edward J. Salopek, M.D.
   Family Practice
Giridhar Santebennur, M.D.
   Medical Oncology
Edward M. Stafford, M.D.
   Otorhinolaryngology
Maaz Syed-Ahmed, M.D.
   Internal Medicine
Nabil E. Zaglama, M.D.
   Medical Oncology

Patrick Alberts
   Senior Vice President
Lauren Altemara, RHIA
   Director, Medical Records
Krista Begonia, RD, LDN
   Clinical Dietitian
Amy Blommel, Pharm.D.
   Clinical Pharmacy
Deborah Burkhardt, RT (R) (T) (CT)
   Chief Radiation Therapist
Diane Cooper, RN, BSN, MSN
   Director, Risk Management/Quality Assurance
Father John Fierro
   Pastoral Care Representative
Eloise Guarinoni, CTR
   Tumor Registry
Michele Haftman, RN, OCN
   Radiation Therapy
Heather Hart, LSW
   Social Worker
Peter Hrycko
   Manager of Oncology
Lisa A. Hruby, RN
   Assistant Vice President, Nursing
Amie Matyas, RN, OCN
   Nurse Manager, Inpatient Oncology Unit
Kathleen Row
   Community Cancer Control Specialist, ACS
Mike Semon
   Chief Radiation Officer
Ruth Sepesky, MPT
   Director, Rehab Services
Dorian Sickles, CMSC
   Director, Medical Staff Services
Angel Swab, RHIA, CTR
   Assistant Director, Medical Records
Denise Thorn, RN
   Medical Oncology
Cheryl Timko, RN
   Assistant Vice President, Nursing
Kathe Wilson
   Medical Staff Secretary

Accreditations, Memberships and Participations

American Cancer Society (ACS)
American College of Radiology (ACR)
American College of Radiology, Committee on Mammography Accreditation of the Commission on Standards and Accreditation
Association of Community Cancer Centers (ACCC)
American College of Surgeons Commission on Cancer as a Community Hospital Comprehensive Cancer Program

Monongahela Valley Hospital
1163 Country Club Road
Monongahela, PA 15063-1095
(724) 258-1000
monvalleynhospital.com

Additional information regarding the Cancer Program at MVH or this report may be obtained by contacting Andrew J. Zahalsky, M.D. at 724-292-9404