

## Lung Cancer Screening Improves Survival

*Joelle Thirsk-Fathi, M.N., ARNP, Lung Cancer Screening Program, Department of Thoracic Surgery, Swedish Cancer Institute*

November is Lung Cancer Awareness Month, which prompts a better understanding of who is at risk for lung cancer and what our medical profession has to offer these patients. Research has shown a significant improvement in the five-year survival rates for those who participate in lung cancer screening. The Swedish Cancer Institute has opened a new lung cancer screening clinic to help detect cancers earlier in high-risk individuals, and to improve the chance of survival in these patients.

Cigarette smoking was at an all-time high in the United States in 1974 when 43 percent of all males and 30 percent of women smoked. Although these numbers declined to 24 percent and 18 percent respectively in 2009 and have since continued to decline, tobacco exposure is still the leading cause of preventable deaths, and lung-cancer deaths have risen by 4 percent in the last decade. Lung cancer is now recognized as the leading cause of cancer deaths, killing nearly twice as many women per year as breast cancer and nearly three times as many men as prostate cancer.

The cost associated with smoking is exorbitant. In 2004, health-care costs attributed to tobacco-related diseases reached \$96 billion. A more tragic cost is the 13 years of life on average lost by each American adult who smokes.

*(continued on A2)*

## Forty Years of Life-Saving Transplants

September 2012 marked the fortieth anniversary of the Swedish Organ Transplant Program. Swedish is one of only four regional transplant centers for adult patients with end-stage organ disease in Washington, Alaska, Idaho and Montana. Since its first kidney transplant in 1972, the program has expanded to include pancreas and liver transplants, and has transplanted nearly 2,000 organs.

“In Washington alone, nearly 1,800 patients are on the waiting list for a kidney, liver or pancreas transplant,” says **Marquis Hart, M.D.**, program director of the Swedish Organ Transplant Program. “In dramatic contrast, to date in 2012 there have been only 203 kidney, liver or pancreas donors in Washington. This supply of viable organs answers less than 12 percent of the need – a supply-and-demand equation that starkly describes the reality of life or death.”

The organ donor shortage can be attributed primarily to lack of public awareness, rather than lack of organs. Working with Life Center Northwest, Swedish is helping raise awareness of this life-giving contribution members of the community can make.

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# Screening for Lung Cancer

(continued from A1)

Lung cancer is the cause of death in 80 percent of women and 90 percent of men whose deaths were related to smoking. Men who smoke are 23 times more likely to get lung cancer than those who don't smoke, and women who smoke have a 13 times greater risk for lung cancer. Eighty-five percent of those diagnosed with lung cancer will die within the first five years of diagnosis.

## Surviving lung cancer

Historically, the five-year survival rate for lung cancer has been 16.3 percent, which means that only a small percentage of all lung cancers are being diagnosed in the earliest and most curable stages. This is a relatively poor prognosis as compared to the rising survival rates in those cancers for which screening tests have been widely accepted, including colon (65 percent), breast (90 percent) and prostate (99 percent). These startling statistics and poor prognoses for those diagnosed with lung cancer are directly related to the lack of screening and early detection of lung cancer. Appropriately, the national strategy for combating lung cancer has thus far been directed at smoking cessation. Today, however, more than 50 percent of newly diagnosed lung cancer in the United States is occurring in nonsmokers or former smokers, and the survival rate has not improved significantly in several decades. A new strategy is needed.

## Benefits of screening

Since 2000, Swedish has participated

in the International Early Lung Cancer Action Program (I-ELCAP), an early-detection study which demonstrated a dramatic improvement in these prognostic numbers. This large, multicenter study used low-dose CT to screen patients who were at high risk for lung cancer. In addition, annual low-dose CT screening of high-risk individuals, ages 55-74 years with a 30+ pack-per-year smoking history, improved the rates of detection and survival, and resulted in a 20 percent reduction in mortality in the National Lung Screening Trial (NLST), which screened 50,000 individuals. These studies demonstrate that low-dose CT is an evidence-based approach to screening and early detection of lung cancer that significantly improves survival.

## A decade of experience

Given its participation in the I-ELCAP study during the last 12 years, the Swedish Cancer Institute (SCI) possesses the most experience in the Northwest in lung cancer screening. The Swedish Lung Cancer Screening Program, in collaboration with the I-ELCAP, has screened more than 1,000 patients and identified 23 early-stage cancers - giving 23 people an opportunity for cure, and greatly improving their odds of long-term survival.

The Swedish Cancer Institute's experience in harnessing the power of research in lung cancer screening has led to the development of a multidisciplinary clinic for lung cancer screening and tobacco related diseases. The clinic follows the I-ELCAP and NLST best

practices and guidelines for screening.

This comprehensive clinic offers individuals who are enrolled in the lung cancer screening program:

- Screening for tobacco-related diseases and lung cancer
- Tobacco cessation counseling and treatment
- A highly experienced, multidisciplinary treatment team of thoracic surgeons, interventional pulmonologist, radiologists and thoracic surgery nurse practitioners

To refer a patient to the Swedish Cancer Institute's Lung Cancer Screening Program, or to learn more about the program, please call **206-386-6800**. 

Data sources: National Cancer Institute, American Lung Association, International Early Lung Cancer Action Program, Centers for Disease Control and Prevention.

## When to Refer to Swedish for Lung Cancer Screening

The Swedish Cancer Institute has more than a decade of experience screening patients for lung cancer. Please call **206-386-6800** to consult or refer a patient who meets the following criteria:

- Age 55-74
- History of smoking 30+ pack of cigarettes per year
- Currently smoking, or quit smoking within the past 15 years

### Swedish Lung Cancer Screening Program

Swedish Cancer Institute  
1101 Madison St., Suite 850  
Seattle, WA 98104  
T: 206-386-6800

[www.swedish.org/LCSP](http://www.swedish.org/LCSP)

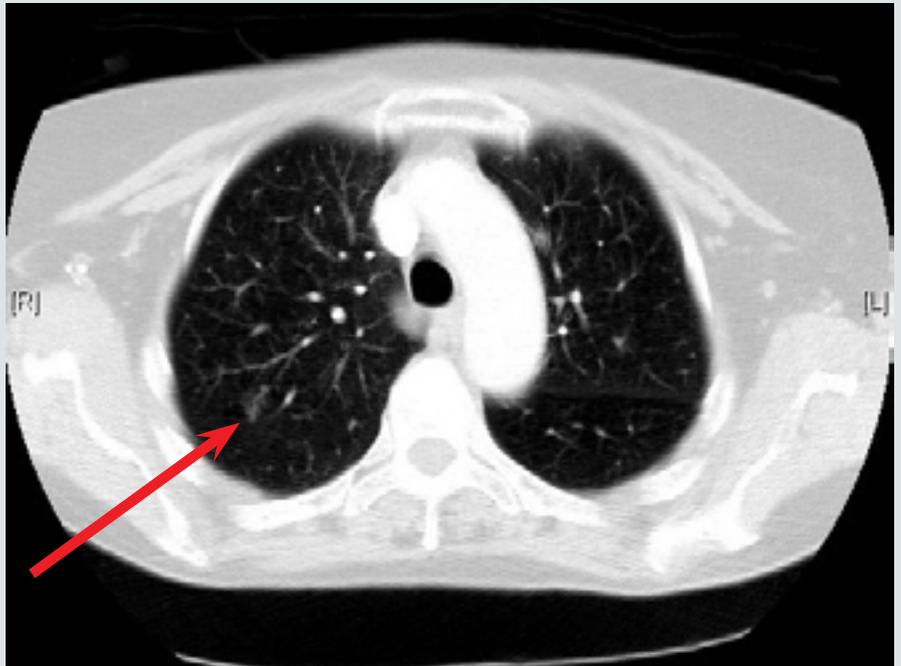
## Case Study: Lung cancer screening

Joelle Thirsk-Fathi, M.N., ARNP, Lung Cancer Screening Program, Department of Thoracic Surgery, Swedish Cancer Institute

A 68-year-old female with a 41-pack year history of smoking, currently smoking five cigarettes daily, has been under annual surveillance by low-dose CT lung cancer screening. On her first scan, small bilateral pulmonary nodules were detected. Following the screening algorithm, low-dose CT scans were performed at shorter intervals to determine if one or more of the nodules demonstrated concerning growth. Per protocol, treatment consisted of antibiotics and observation for these semi-solid nodules. On follow-up scans, the right upper lobe nodule began to show worrisome growth, while the other nodules remained stable in the background.

On repeat follow-up imaging, the nodule had continued to grow. The patient then underwent a right VATS (video-assisted thoracic surgery) wedge resection of the right upper lobe with wire localization. The nodule was determined to be a bronchoalveolar carcinoma (BAC), 0.9 cm X 0.6 cm with clear margins: pT<sub>a</sub>, pN<sub>x</sub>.

Fortunately, this patient was undergoing regular screening, this small nodule detected was an early Stage I lung cancer, and the resection on the right was complete. ☺



The arrow in this CT image identifies the right lung nodule prior to resection.

## Pipeline<sup>®</sup> Embolization Device Offers a New Option for Treating Aneurysms

Until recently, standard treatment options for cerebral aneurysms have included observation without intervention, surgical clipping, primary coiling without a stent, stent-assisted coiling and bypass with parent artery sacrifice. The Swedish Cerebrovascular Center has added a new option to its aneurysm-treatment arsenal – the Pipeline<sup>®</sup> stent. This stent, which has been used in Europe since July 2009, was made available in the United States in mid-2011 following approval by the U.S. Food and Drug Administration FDA.

The Pipeline stent is a new class of embolization device that diverts blood flow away from the aneurysm, and provides complete and durable embolization while maintaining patency

of the parent vessel. It can be used to treat large or wide-necked intracranial aneurysms.

“In the several large Pipeline series performed outside of the United States prior to FDA approval of the device, the mortality and morbidity of this procedure was slightly higher than primary coiling,” says **Yince Loh, M.D.**, a neuro-interventional radiologist with the Swedish Cerebrovascular Center. “This finding, however, must be taken in the context of difficult-to-treat aneurysms, such as the one presented in the following case study. When the periprocedural risk of complications with conventional endovascular methods is exceedingly high, such as it is with

*(continued on A6)*

### Why Refer to Swedish?

Research has shown that hospitals that treat more than 25-50 aneurysms annually have better outcomes. Neurosurgeons at the Swedish Cerebrovascular Center evaluate more than 500 patients with aneurysms each year. This is one of the highest volumes in the Pacific Northwest, highlighting the medical staff's experience in recognizing the subtleties of different types of aneurysms, as well as in recommending and providing the optimal treatment option for each patient.

The Swedish Neuroscience Institute (SNI) offers specialized cerebrovascular diagnostic testing, and has highly specialized operating rooms and endovascular suites to support surgical and endovascular treatment of cerebral aneurysms.

#### Swedish Cerebrovascular Center

550 17th Ave., Suite 110

Seattle, WA 98122

Phone: 206-320-3470

Fax: 206-320-3471

For urgent transfers, please call  
866-470-4233 (toll free).

# 40 Years of Life-Saving Transplants

(continued from A1)

## Kidney transplant

Swedish provides kidney transplants using matched kidney donations from deceased individuals, as well as both living-related and living-unrelated-donors. In response to an increasing interest in living organ donation in the community, Swedish established the Swedish Benevolent Community Donor Program in 2002 – the first of its type on the West Coast and one of the few organized programs in the country. The BCD program allows an altruistic individual to donate a kidney without having a specific recipient in mind. Now in its 10th year, the BCD program has joined with Swedish's paired exchange program to expand the reach of this generosity – triggering kidney transplants in two or more individuals.

The Swedish transplant program is also one of the few programs in the country that will consider high-BMI patients for transplant – a growing need in the United States.

“In many transplant centers, these patients are not considered candidates for transplant due to their co-morbidities,” says **Lisa Florence, M.D.**, director of the Swedish Kidney Transplant Program. “We carefully assess each patient and then, working with the Swedish Bariatric Program and our transplant dietitian, we develop an individualized approach to these obese patients who are in need of kidney transplant.”

The kidney transplant program at Swedish brings together specialists from nephrology, cardiology, infectious disease, vascular, pathology and radiology to ensure safe and successful kidney transplants. This approach has allowed patients with challenging

medical conditions to safely receive a transplant and have long-term success. The Swedish one-year kidney survival rate exceeds the national average.

## Liver transplant

Liver transplantation is the only option for patients facing imminent liver failure or end-stage liver disease. Cirrhosis, viral hepatitis, genetic disorders, metastatic liver cancer, autoimmune disorders, obesity, and toxins and drugs can be factors that cause end-stage liver disease and liver failure.

Swedish performed its first liver transplant in 2010.

Liver transplantation is highly successful, with more than 80 percent of patients going on to live as long-term survivors. Surgical improvements have decreased the risk of death from

complications to less than 5 percent, while improvements in immunosuppression have decreased the risk of losing the graft due to rejection to less than 5 percent.

## Pancreas transplant

More than 80 percent of pancreas transplants are performed on patients with diabetes at the same time as – or shortly after – a kidney transplant. The pancreas and kidney transplant teams work together to develop individualized and comprehensive solutions to patients requiring pancreas transplantation. Patients with Type I diabetes who have preserved kidney function but have severe complications from diabetes are considered for isolated pancreas transplantation. Some Type 2 insulin-dependent diabetes patients also may be candidates for pancreas transplant.

For more information about the Swedish Organ Transplant Program or to consult on a patient, please call **206-386-3660** or toll free **800-99ORGAN (800-996-7426)**. 

## Swedish Transplant Program Milestones

1972-2012

- 1972 First kidney transplant
- 1995 First kidney/pancreas transplant
- 2000 First donor nephrectomy (laparoscopic kidney donor)
- 2002 Swedish Benevolent Community Donor Program established
- 2006 First paired exchange kidney donation
- 2008 First isolated pancreas transplant
- 2010 First liver transplant
- 2012 First robotic donor nephrectomy
- 2012 First robotic liver resection
- 2012 First simultaneous liver/kidney transplant

**Total organ transplants (1972-2012):**  
1,963 (as of 9/17/12)

## When to Refer to Swedish

### Swedish Transplant Program

Swedish/First Hill  
1101 Madison St., Suite 200  
Seattle, WA 98104  
Phone: 206-386-3660  
Toll free: 800-99ORGAN (800-996-7426)  
Fax: 206-386-3644

The Swedish liver transplant team has more than 50 years of combined experience in liver transplantation and in caring for patients with chronic and acute liver failure. The kidney transplant team has more than 70 years of combined transplant experience, and has transplanted more than 1,800 kidneys.

## Delivering the Most Appropriate Radiation Therapy

The Swedish Cancer Institute (SCI) installed the first high-energy X-ray therapy machine in the western United States in the early 1930s. Now, more than eight decades later, the SCI continues its commitment to improving patient care by ensuring it maintains an arsenal of the most up-to-date technologies.

Few hospitals are able to offer more than one advanced targeted radiation technology. Advancements in the delivery of radiation suggest one technology cannot attempt to meet the needs of every patient. With six locations and more than a dozen radiation-therapy platforms, the radiation oncologists at the Centers for Advanced Targeted Radiation Therapy (CATRT) at Swedish are able to customize treatment plans for patients from throughout the Pacific Northwest and beyond. Patients are reassured that they will be treated with the specific technology that delivers the highest dose of radiation possible to

### When to Refer to Swedish

The Centers for Advanced Targeted Radiation Therapy (CATRT) welcomes patients for initial consultations and second opinions. The CATRT offers the most comprehensive menu of radiation therapy options on the West Coast. Radiation oncologists at the CATRT are able to provide patients the reassurance that they are receiving the most appropriate therapy.

#### SCI Radiation Treatment Center

Swedish/Ballard  
206-386-6707

#### Swedish Radiosurgery Center

Swedish/Cherry Hill  
206-320-7130

#### SCI at Edmonds

Swedish/Edmonds  
425-640-4300

#### SCI Radiation Oncology

Swedish/First Hill  
206-386-2323

#### SCI at Issaquah

Swedish/Issaquah  
425-313-4200

#### SCI at Highline Radiation Oncology

Burien, Wash.  
206-386-2626

the treatment target, while healthy tissue receives no radiation or the lowest, safest dose.

“Swedish radiation oncologists have been pioneers in the development and implementation of new radiation technologies to improve the treatment of cancer,” says **Vivek K. Mehta, M.D.**, medical director for the CATRT. “We regularly work with industry leaders to help develop new radiation delivery systems. For example, we enrolled

patients in one of the first trials of partial breast radiotherapy using the Mammosite<sup>®</sup> and Xofig<sup>®</sup> devices, and have substantial experience with Active Breathing Controller<sup>®</sup> – technologies that help protect the heart from residual radiation while treating breast cancer.”

The CATRT welcomes patients for initial consultations or second opinions. For more information, please call **206-386-2323**. ☎

### Case Study: Breast Cancer

*Vivek K. Mehta, M.D., Medical Director, Centers for Advanced Targeted Radiation Therapy, Swedish Cancer Institute*

Samantha Smith had a lumpectomy and sentinel lymph node dissection at a local hospital. Her surgeon told her she had a small cancer in her breast, which he had removed entirely. During her initial radiation therapy consultation, the radiation oncologist told her that her heart would receive “some” radiation during radiation therapy and that this was unavoidable.

Before agreeing to treatment, Ms. Smith decided to research radiation therapy options for breast cancer. She discovered that she might be a candidate for partial breast radiotherapy using the MammoSite<sup>®</sup> or Contura<sup>®</sup> devices. She also learned that TomoTherapy<sup>®</sup> could sculpt the dose and avoid the heart. And, finally, she found that Active Breathing Coordinator<sup>®</sup> provided a solution for treating the entire breast, while avoiding the heart.

In searching for facilities that offered a variety of radiation therapy options, Ms. Smith learned

that the Swedish Cancer Institute (SCI) offered all of the therapies she had read about, as well as several others. She decided to transfer her care to the SCI's Radiation Oncology Department.

Prior to her first appointment at the SCI, we reviewed Ms. Smith's pathology and imaging studies. A radiation simulation study demonstrated that it would be nearly impossible to avoid the heart with standard radiation techniques. When we met with her, we offered her three treatment approaches that would eliminate the dose of radiation to her heart. These options included:

- Whole breast radiotherapy with Active Breathing Coordinator, which offers standard breast radiotherapy but eliminates the heart dose
- Partial breast radiotherapy using High Dose Rate Radiotherapy, which reduces the treatment time to one week and only treats the highest risk region in the breast

- TomoTherapy, which utilizes an arc-based intensity modulated treatment approach to avoid the heart

The patient elected to proceed with the conventional radiotherapy approach, but opted for the Active Breathing Coordinator technique. Active Breathing Coordinator effectively treats the breast with radiation during the instant in time that the heart and breast tissue are furthest apart. The machine assesses this during each treatment and the radiation is delivered only during that optimal window. The side effects from the treatment are the same as for any whole breast radiotherapy treatment, except that the heart does not receive any unnecessary doses of radiotherapy. In our experience, nearly all women who might benefit from this approach are able to complete this type of treatment.

*(See page A7 for a second radiation therapy case study.)*

## Pipeline® Embolization

(continued from A3)

intracranial aneurysms exerting mass effect, a method such as Pipeline embolization is an attractive alternative.”

The Pipeline embolization device (*shown right*) comprises 48 braided strands of cobalt chromium and platinum tungsten. This scaffold, which is delivered through a micro-catheter, allows for the growth of endothelial cells over the aneurysm. Over time a permanent biological seal forms across the diseased parent artery, minimizing the risk of rupture. ☞



Photo courtesy of Covidien.

### Case Study: Use of Pipeline® stent for carotid-ophthalmic aneurysm

Yince Lob, M.D., Cerebrovascular Center, Swedish Neuroscience Institute

A 61-year-old female presented with progressive vision loss in her left eye. She had a history of hyperlipidemia, hypertension, obesity, diabetes, chronic renal insufficiency, anemia of chronic disease, sleep apnea, diabetic peripheral neuropathy and depression. Cranial imaging demonstrated a large left carotid-ophthalmic aneurysm. The patient was referred to The Swedish Cerebrovascular Center at the Swedish Neuroscience Institute for further management. Catheter angiography confirmed the presence of the aneurysm, as well as a smaller aneurysm immediately distal to the larger one (*Figure A*).

The center's cerebrovascular team jointly evaluated her and considered surgical clipping, primary coiling without a stent, bypass with parent artery sacrifice and Pipeline embolization. The team felt that primary coiling would very likely worsen her vision after the placement of rigid coils in the aneurysm, and that primary clipping or bypass-sacrifice would be risky given her multiple surgical risk factors. Although we presented bypass-sacrifice as the lowest risk of further vision loss and the standard of care for this type of aneurysm to date, we also offered Pipeline embolization as an alternative with less surgical risk, preservation of the parent artery and an excellent chance to minimize further mass effect on the aneurysm. The patient chose Pipeline embolization.

She was placed on aspirin and Plavix® several days prior to the procedure, and we confirmed anti-platelet reactivity. Under general

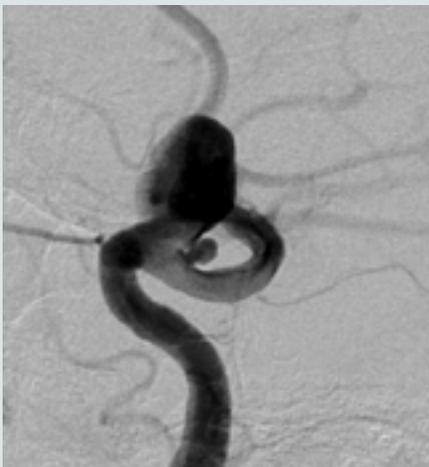


Figure A

anesthesia, a single Pipeline embolization device was deployed to cover both aneurysms (*Figure B*). Immediately following device deployment, we noted stagnation within the aneurysm. The procedure lasted less than one hour.

The patient was discharged the next day on a short burst of prednisone, along with aspirin and Plavix.

We saw the patient in clinic for follow up a month later. There was minimal decline in her vision. After cessation of Plavix at five months, her six-month follow-up angiography demonstrated complete occlusion of the aneurysms (*Figure C*). She is currently doing well and needs no further follow-up. ☞

*This case study is presented for educational purposes.*



Figure B

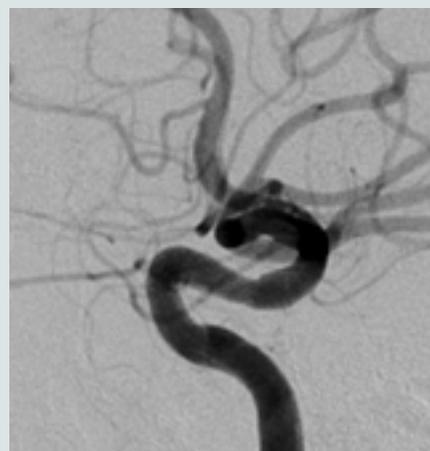


Figure C

## Radiation Therapy

(continued from A5)

### Case Study: Metastatic disease near the spine

Vivek K. Mehta, M.D., Medical Director, Centers for Advanced Targeted Radiation Therapy, Swedish Cancer Institute

Rick Jones was diagnosed with metastatic lung cancer. He was treated with chemotherapy and radiation at a local hospital.

Following treatment, Mr. Jones came to the Swedish Cancer Institute (SCI) to participate in a clinical trial of a new medication. The drug worked very well controlling his cancer for nearly 10 months.

Mr. Jones began experiencing increased pain. Imaging studies demonstrated that the cancer had returned and was now invading the vertebral bodies. Unfortunately, the recurrence was within the prior radiation field. During his first course of treatment, the spinal cord adjacent to this tumor mass had been treated to the upper limit of safe radiation doses.

A radiation oncologist at the SCI evaluated Mr. Jones and recommended treatment with stereotactic radiosurgery, which would precisely deliver a high dose of radiation, while avoiding healthy tissue that had received

residual radiation during his initial treatment.

Using the CyberKnife® stereotactic radiosurgery platform, we were able to precisely aim the radiation at the cancerous tissue. The CyberKnife system tracks the tumor to account for tumor motion. Therefore, we were able to treat just the cancer and did not need to add the “extra” safety margin required by other treatment platforms. Dosimetrically, we were able to treat the cancer to the biological equivalent of six weeks of radiation, but the patient received those doses in just three visits. The patient’s spinal cord, which had already been treated, remained safe because the treatment plan accounted for the prior dose and the beams were aimed to avoid overlap. The patient’s pain resolved within two weeks following the last treatment. Subsequent imaging studies showed tumor shrinkage and control of his disease. ☞

*The radiation therapy case studies are presented for educational purposes. The patients’ names have been changed.*

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Physicians from across the region and around the world come to Swedish Medical Center’s Continuing Medical Education (CME) courses to learn about new research and innovative treatment techniques.

For times and locations, go to [www.swedish.org/cme](http://www.swedish.org/cme) or call 206-386-2755.

#### The Transradial Approach: A Case-Based and Hands-On Training Course

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#### Advances in Neuromodulation 2012: State-of-the-Art and Emerging Indications

Friday, Nov. 9

#### Orthopedic Symposium for the Primary-Care Physician

Friday, Nov. 9

#### 26th Annual Roland D. Pinkham, M.D., Basic Science Lectureship: Bioengineering in 2012 – Toward the Bionic Man

Friday, Nov. 16

#### Ninth Annual Pediatric Specialty Update for the Primary-Care Physician

Friday, Jan. 25

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## Swedish Medical Center

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#### Ballard

5300 Tallman Ave. N.W.  
Seattle, WA 98107-3985  
206-782-2700

#### Cherry Hill

500 17th Ave.  
Seattle, WA 98122-5711  
206-320-2000

#### Edmonds

21601 76th Ave. W.  
Edmonds, WA 98026  
425-640-4000

#### First Hill

747 Broadway  
Seattle, WA 98122-4307  
206-386-6000

#### Issaquah

751 N.E. Blakely Dr.  
Issaquah, WA 98029  
425-313-4000

#### Lakeside

6506 226th Pl. S.E.  
Issaquah, WA 98027  
425-427-8450

#### Mill Creek

13020 Meridian Ave. S.  
Everett, WA 98208  
425-357-3900

#### Redmond

18100 N.E. Union Hill Road  
Redmond, WA 98052  
425-498-2200

#### Swedish Medical Group

600 University St., Ste. 1200  
Seattle, WA 98101-1169  
206-320-2700

## Physician Opportunities

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Contact Aaron Bryant  
Manager, Provider Services  
Swedish Medical Group at  
[aaron.bryant@swedish.org](mailto:aaron.bryant@swedish.org)  
or 206-320-5925.