Cancer Committee Members

Eileen Johnston, M.D.
Oncology/Hematology
Cancer Committee Chair

Daniel Markowitz, M.D.
Oncology/Hematology
Cancer Liaison Physician

Alan Boudousquie, M.D.
Pathology

Carol Cornejo, M.D.
General Surgery

Ernest Kawamoto, M.D.
Pathology

Keith Luther, M.D.
Internal Medicine

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Urology

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Pain Management

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Gastroenterology

Roger Shelton, M.D.
Gynecology

Sally Browning, M.D.
Radiology – Breast Center

Robert Takamiya, M.D.
Radiation Oncology

Jeffery Ward, M.D.
Oncology/Hematology

Judy Cody, BSN, CTR
Tumor Registry

Darlene Hetrick, R.N.
Clinical Manager, Surgical Oncology

Tawnia Kemp, CTR
Tumor Registry

Susanne Kromberg
Spiritual Care Manager – Staff Chaplain

Heather Lingbloom, RHIA
HIM Dept. Operations Manager

Pam Martino, RHIT
Quality Management

Julie Norman, RD, CD, CDE
Nutritional Services

Maxine Riordan, MSW
Social Services

Jerri Wood
Quality of Life Manager
American Cancer Society

Nancy Wood, R.N.
Chief Nurse Executive
As chairman of the Swedish/Edmonds Cancer Control Committee, it is my pleasure to offer this update regarding the cancer-care program at our facilities. It has been an exciting year for patients and caregivers in our area. As many of you are aware, Swedish/Edmonds, formerly Stevens Hospital, is now fully affiliated with Swedish Health Services. This affiliation is the culmination of months of effort by countless administrators, medical staff, board members and members of our community. The successes we have already enjoyed are just the beginning of what we anticipate will be a long and fruitful relationship with our colleagues to the south. We have already seen increases in patient visits to our facilities and an improvement in staff morale as we feel we have a clear direction for our future right here in Edmonds. In the ensuing months we anticipate the implementation of an electronic medical record at our hospital, expansion and improvements in our Emergency Department and the addition of various medical subspecialists to our medical staff. Patient comforts including updated lobby areas, improved on-demand dining and a resource library are already in place. Many additional plans are in development, both small and large scale.

While our new status as a Swedish facility is affecting many of our activities, it has not changed our pre-existing, deep-rooted commitment to the community we serve. We have many cancer-related programs that we are continuing to develop, now with the assistance and good-will of our new administrative partners. In 2010, Swedish/Edmonds installed a state of the art PET/CT machine. This technology helps our physicians evaluate the stage and location of cancers and makes treatment planning more precise and personalized. Combining the data obtained from separate PET and CT exams into one comprehensive study resolves many of the ambiguities previously faced by our caregivers and decreases the number of tests our patients must endure.

The Swedish Edmonds Breast Center has continued to develop into a regional center of excellence. Digital mammography, breast MRI, ultrasound and biopsies are performed by our compassionate and knowledgeable breast radiologists and their staff. Our services include a breast care navigator who assists those with newly identified breast-health concerns get prompt imaging, biopsy results and physician referrals. Our goal is that our patients always feel secure in their knowledge of the next step and how they will get to it. Our breast navigator is also a great resource for patients looking for reading and Internet information as well as community support services. Our medical oncologists offer genetic counseling and testing for hereditary breast-cancer risk and offer risk reduction strategies for all interested women with breast-cancer concerns. Our providers continue to participate in a weekly breast cancer conference during which nearly every new breast-cancer diagnosis is reviewed with provision of a multidisciplinary review and recommendations.

We continue to work closely with the American Cancer Society to provide and expand our cancer support services. Whether our patients need help with transportation, information, wig acquisition, or just a kind ear, we have an amazing group of volunteers ready and anxious to help. In 2010 we served over 160 people
in our Cancer Resource Center. We are anticipating further development of our support services as we continue to work within Swedish Health Services.

In October 2010, our cancer program underwent a review by the American College of Surgeons Commission on Cancer, routinely performed every 3 years. I am happy to report that our program was not only fully accredited (as we expected), but we also received multiple commendations by the review board for our outstanding performance in various areas including pathology reporting and educational activities. The reviewer labeled our program “exemplary.” The level of commitment required of our providers and staff to accomplish this designation is something we promise to continue and grow year after year.

Whether as patient, provider, family member or community resident, we all face concerns about the future of health care in our country. A serious illness such as cancer can raise concern to a level of outright fear. As a medical community we have listened carefully to our patients and we have added our own expertise in making decisions about the direction we are headed with Swedish/Edmonds. We sincerely appreciate your confidence and trust as we make our plans a reality and continue to provide to you exceptional care, close to home.

Eileen Johnston, MD
Oncology/Hematology
Cancer Committee Chairman

Puget Sound Cancer Centers

Puget Sound Cancer Center (PSCC), Edmonds is a medical group of five physicians working with dozens of excellent nurses and staff members. Our physicians are all board certified and specialize in medical oncology and hematology. Together, our doctors have over 100 years of experience treating patients with all types of cancer as well as blood disorders, both benign and malignant. The quality of our care has been recognized by The American Society of Clinical Oncology which has certified us in the Quality Observation Performance Initiative (QOPI), a distinction granted to a minority of medical oncology practices. We provide state-of-the-art care, including a variety of clinical trials which provide for innovative treatments not yet widely available. Our physicians strive for clinical excellence everyday, but also distinguish themselves as leaders in the local, regional and national medical communities serving as hospice director of Snohomish County, immediate past chief of the Swedish/Edmonds medical staff, chairman of the Cancer Control Committee of Swedish/Edmonds, president of the Washington State Medical Oncology Society, associate editor of the Journal of Oncology Practice to name a few.

The staff at PSCC has also demonstrated a commitment to our patients and our community. Our nurses are oncology certified and undergo annual competency reviews. Like our physicians and nurses, every person working at PSCC feels that it is a privilege to work with our patients, treating each with respect, compassion and empathy. A devotion to those battling cancer extends beyond the work day with our staff often participating in extracurricular cancer fundraisers including the
annual American Cancer Society’s Relay for Life. It is a common sentiment to hear our patients proclaim that although they would not wish cancer on anyone, they feel fortunate to have grown personally through the experience, and to work with such dedicated professionals in their pursuit of health. We are proud to provide such an environment.

The physicians at PSCC are grateful to work in the collegial, professional, quality-driven community anchored by Swedish/Edmonds and Swedish Health Services. The pathologists, radiologists, surgeons, radiation oncologists and other health-care professionals in our community are committed to the well-being of your family and will consistently go to extremes to ensure it.

We are grateful for the trust the community has placed in us and we look forward to the challenges ahead of us in this changing world of health-care delivery.

Swedish Cancer Institute at Swedish/Edmonds

The Swedish Cancer Institute at Swedish/Edmonds remains committed to delivering the highest quality treatment using state-of-the-art equipment in a patient-centered care environment. Fully one-third of our patients receive treatment with intensity-modulated radiation therapy (IMRT), a technique which improves accuracy, minimizes toxicity, and increases radiation dose thereby improving cure rates. We offer the most advanced form of IMRT called image guided radiation therapy (IGRT). Implanted fiducial markers allow visualization of the target area with each treatment, which in turn allows for smaller treatment fields and fewer side effects than standard IMRT. We continue to offer samarium and strontium therapy, an intravenous targeted radionuclide used for palliation of painful bone metastases. We also offer radioactive monoclonal antibody therapy in appropriate patients with lymphoma. Comprehensive services, including physics and dosimetry support, radiation oncology nursing, radiation therapists, social services, and nutritional counseling, are available to provide individualized and compassionate care to patients and their families.

An in-house CT-simulator helps us maintain our world-class standard of care. This provides more convenient patient service by allowing the treatment planning visit to take place all under one roof. The model is a large bore CT, which will enhance patient comfort and optimize patient positioning. This CT has 4-D radiation treatment capabilities, which accounts respiratory motion.

We have a robust prostate brachytherapy program at Swedish/Edmonds. Utilizing the new urology operating suite, we have all new, high-end equipment. Prostate brachytherapy is the implantation of radioactive seeds to cure prostate cancer with a high degree of precision utilizing ultrasound guidance. Long-term data confirms cure rates equivalent to surgery but without many of the surgery-related morbidities. Our association with the Seattle Prostate Institute was instrumental in building this program and offering it to our community.
Through participation in the weekly Swedish/Edmonds Tumor Board and close cooperation with our medical oncology colleagues, surgeons and other specialists at Swedish/Edmonds, we continue to offer the most up-to-date multidisciplinary treatment approaches to our patients. Our alliance with the other Swedish Cancer Institutes, Seattle Prostate Institute, and the Tumor Institute Radiation Oncology Group allows us to offer all modern radiation oncology services. This includes Gamma Knife and Cyberknife radiosurgery, high-dose-rate brachytherapy for gynecologic and urologic malignancies, systemic radiation therapy, external beam radiation therapy (IMRT-IGRT) and the premier radioactive seed implantation program in the United States. Due to our technology and expertise, residents and fellows from the top training programs in the country regularly travel to Seattle to observe these therapies.

New Cancer Center Opening Spring 2012

Swedish is committed to providing seamless, personalized care that’s close to home and plans to enhance the experiences of patients and their families with the opening of expanded facilities and services at Swedish/Edmonds.

A new two-story, 16,000-square-foot building to expand the cancer program is anticipated to open in spring 2012. The new cancer building will feature:

- A medical oncology suite with physician services provided by Puget Sound Cancer Centers
- Chemotherapy and infusion services
- Patient-care areas with enhanced patient privacy and comfort

In addition to the new medical oncology center, there will be exciting new changes to the hospital’s existing Swedish Cancer Institute facility. Plans are under way for the first floor to accommodate a new linear accelerator (linac) — technology commonly used for cancer radiation treatments. A linac works by delivering a uniform, high-energy X-ray dose to cancer tumors. The precision and accuracy of the X-ray dose destroy cancer cells while sparing the surrounding normal tissue.

The existing cancer facility’s second floor will also undergo changes and is planned to house a new cancer patient resource center. The space will provide patient and family-centered education, social services and meeting rooms for support groups, as well as space for specialists and integrated cancer-care providers.

More than 2,600 cancer patients were cared for by the Swedish Cancer Institute, Puget Sound Cancer Centers and other local cancer-care providers affiliated with Swedish/Edmonds in 2010. The expansion and coordination of cancer services will allow Swedish/Edmonds to serve even more patients for many years to come.
Swedish/Edmonds Cancer Conferences

Tumor Board Conferences are held weekly at Swedish/Edmonds with presentations based on all types of cancers. Special attention is given to present the top five cancers seen at Swedish/Edmonds.

In March 2009 a separate, weekly site specific breast conference was established. With the initiation of the breast conference, the number of breast cases being presented doubled in 2009 as compared to 2008. See chart below.

These conferences bring together dedicated specialists from radiology, pathology, surgery, medical and radiation oncology, as well as physicians from other specialties and allied health professionals, to review and discuss the medical condition and treatment options of patients for whom a multidisciplinary approach is being considered.

A case presentation includes a patient’s medical history, clinical findings, diagnostic studies, treatment modalities and research data.

The Commission on Cancer requires that 10 percent of Swedish/Edmonds annual analytic cases are discussed. In 2009, 309 cases were presented. Out of the total annual case load of 534 cases for 2009, 58 percent were presented at cancer conferences. All top five sites were presented.
The Cancer Registry is one of the major components of our comprehensive cancer program at Swedish/Edmonds. The registry staff, under the supervision of the Cancer Control Committee, is responsible for maintaining state and national cancer reporting requirements, coordinating Cancer Conferences, and providing support for all cancer program activities required for accreditation by the American College of Surgeons Commission on Cancer.

The registry has been collecting data on all cancer patients diagnosed and/or treated at Swedish/Edmonds since January 1, 1974. Data collected includes patient demographics; cancer identification, treatment and follow up. These data contribute to treatment planning, staging and the continuity of care for patients. Accurate and complete registry data are the underpinnings that permit Swedish/Edmonds to plan and optimize its cancer program. Since 1974, 14,826 cases have been collected in the registry.

In 2009, Swedish/Edmonds diagnosed and/or treated 534 new cancer cases. The five most frequently treated cancers at Swedish/Edmonds in 2009 included breast, prostate, lung/bronchus, leukemia/lymphoma/myeloma, and colon/rectum. See chart below. In comparing the five most frequently treated cancers at Swedish/Edmonds with national rates, Swedish/Edmonds’ treatment of breast is almost double that of national rates. Lung and colorectal cancers are slightly lower than national rates, with the incidence of prostate cancer slightly higher. In 2008, lymphoma/leukemia/myeloma cases were slightly lower than the national rate, but in 2009, showed a slight increase for Swedish/Edmonds. See chart above.

Annual follow-up is an important function of the Cancer Registry and is beneficial in reminding attending physicians and patients that routine medical examinations are encouraged. This process may potentially bring lost patients back under medical supervision. Continued surveillance ensures early detection of a possible recurrence or a new primary malignancy. Follow-up also provides a valid measurement of outcome/survival.
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Figure 1
Swedish/Edmonds 2009 Analytic Cases (534)
*Source for National percentages:
2009 American Cancer Society, Inc. Surveillance and Health Policy Research

Cancer of the Head or Neck

Cancers of the head and neck region represent a wide range of diseases, all of which occur in extremely sensitive parts of the human body. Simply by virtue of their location, these tumors can threaten a patient’s ability to eat, drink, swallow, see, or breath, in addition to threatening the person’s life. Many patients seek medical care with disease which has already begun to compromise one or more of these key bodily functions. On first receiving a diagnosis of a head and neck cancer, most patients will be facing decisions which will have tremendous impact on both their quality of life and on whether or not they will ultimately survive. They need information. They need options… and they need answers. Our role as members of the Swedish/Edmonds interdisciplinary head and neck oncology team is to ensure that each patient receives the very best treatment available. Our goal is to find the answer for each individual patient which will protect their quality of life while ensuring their best chance of survival.

At the heart of this process is the interdisciplinary team itself which consists of the otolaryngologist, radiation oncologist, pathologist, radiologist, oncology-certified nurse and the medical oncologist, all of whom meet regularly to discuss each individual patient’s case. Other services are sometimes included in the optimizing of our recommendations including gastroenterology, speech pathology, nutrition and social services. It is our goal to present to the patient his/her treatment options and to honestly represent the potential benefits and the potential dangers associated with each proposed treatment.
We know and respect that it is ultimately the patient who must decide which course of action is best. We are all there to help.

Fortunately, head and neck cancers are often curable even when the disease has presented with severe symptoms or is locally advanced (having already spread to surrounding structures or lymph nodes). Treatment schemas include a bewildering variety of strategies, including surgery alone, radiation alone, combined modality chemoradiotherapy plus or minus surgery, surgery followed by radiation, and induction chemotherapy followed by chemoradiotherapy. In addition, novel targeted drug therapies are increasingly being integrated into first line treatment approaches and there are growing opportunities for patients to participate in national clinical trials. In all of our deliberations, we are mindful of trying to preserve quality of life and we often have the ability to pursue upfront organ sparing treatments rather than proceeding immediately with definitive, yet potentially disabling surgical resections of involved vital structures. On the other hand, we rely on the expertise of our surgeons to proceed with upfront resection of the tumor if that is felt to be in the patient’s best interest. Our surgeons also have the ability to proceed with resection after other treatment modalities (such as chemotherapy or radiation) have been tried if those attempts have not yielded a high enough likelihood of cure. We call this surgical salvage.

With the benefit of interdisciplinary input our patients receive treatment which integrates cutting edge technology. Treatment plans utilize the latest in radiation oncology technologies, novel surgical techniques and the integration of novel chemotherapy agents and targeted therapies. On the other hand, we combine this commitment to providing cutting edge treatment for each patient with a very old school treatment philosophy. We believe in personal commitment of the physician to the patient. Our physicians take a personal interest in the health and well-being of each of our patients. We are available day or night when problems arise. This is particularly important when caring for patients with head and neck cancer as the complex treatment modalities can be fraught with risk. It is by knowing our patients, their histories and medical issues, their strengths and their vulnerabilities, their goals and their wishes, that we are best able to serve our patients when a crisis does occur.

Several of our physicians have collaborated to provide an overview of the roles of each specialist in treating patients with head or neck cancer. Their perspectives are provided below.

**The Pathologist**

Despite the relatively small area of the human body occupied by the head and neck it contains many vital structures. A variety of benign tumors and cancers can arise from the structures of the head and neck. Excluding the brain and its coverings, the head and neck structures include the eyes, the compartments of the ears, sinuses, the nasal passage, tooth forming tissues, mouth, pharynx (including tonsils), salivary glands, thyroid, parathyroid glands, larynx, hypopharynx (the space between the pharynx and larynx), blood vessels, nerves, and soft tissue. The diverse pathologic processes of these structures have resulted in a subspecialty of pathology called head and neck pathology. Neuropathology, a subspecialty of pathology dealing with brain abnormalities, is not generally considered to be a part of head and neck pathology.

The most common cancer of the head and neck,
Squamous cell carcinoma, generally involves the lining of the mouth, pharynx, hypopharynx and larynx. Typically there are many genetic and molecular alterations in cancers, but so far molecular studies of squamous cell carcinomas of the head and neck are not helpful therapeutically. Therefore, the pathologic identification of squamous cell carcinomas is based on the standard H&E (hematoxylin and eosin) stained tissue sections. Certain molecular tests, however, may help in assessing the prognosis of a squamous cell carcinoma in a specific patient and studies in this area are ongoing.

The pathologic assessment of squamous cell carcinomas in either biopsies or in surgical resections is performed with attention to details that inform the surgeon, oncologist, and radiation oncologist about how aggressive an individual carcinoma may be. These details include the size of the carcinoma, how deeply the carcinoma invades into tissues, the microscopic pattern of invasion, and whether invasion is seen in blood vessels, lymphatic channels or nerves. For resections, the distances between the carcinoma and the healthy tissues (the margins) are also noted. When dissections of neck lymph nodes are performed, complete identification of all lymph nodes and their involvement by the carcinoma is also evaluated.
The Surgeon

Historically, the management of advanced head and neck squamous cell carcinoma was based on surgical resection followed by postoperative radiation therapy. Surgical management of advanced laryngeal and pharyngeal tumors often involved loss of the voice box (total laryngectomy), tongue base resections, tonsillar resections and neck dissections. At times, additional surgery was required to gain access for adequate surgical resection, such as splitting of the mandible. These types of procedures often led to permanent deficits with respect to speech and swallowing function and carried with them the possibility of a poor cosmetic outcome.

In an attempt to preserve laryngeal function for patients with advanced larynx cancer, a novel approach of treating patients with induction chemotherapy followed by radiation therapy was first examined in the 1980s. Early studies were able to show that chemotherapy followed by radiation therapy was an effective treatment for advanced laryngeal cancers with the benefit of laryngeal preservation in two-thirds of patients.

Since that time, integration of chemotherapy with radiation therapy has become widely accepted as definitive, primary therapy for a variety of advanced head and neck squamous cell carcinomas. The role of the surgeon has necessarily evolved with the development of combined chemoradiation therapy approaches for the definitive management of advanced head and neck cancer. Although primary surgical resection is no longer the most commonly selected initial therapy for patients presenting with advanced laryngeal and pharyngeal carcinomas, the surgeon remains an important figure in a multidisciplinary team that manages these complex patients.

In contrast to advanced tumors of the pharynx and larynx, primary surgical management remains the initial treatment of choice for squamous cell carcinoma of the oral cavity and tumors involving the facial skeleton; including the mandible, maxilla, paranasal sinuses and temporal bone. In addition, small tumors of the glottis (vocal cord) may be treated definitively with either surgery or radiation therapy alone.

Establishing the pathologic diagnosis of head and neck cancer remains a key responsibility of the head and neck surgeon. While a clinical diagnosis can often be obtained by a combination of patient history, physical exam and imaging studies, obtaining tissue for pathologic diagnosis is an essential first step. The initial biopsy can be done in the operating room or the clinic.

Further tumor assessment often requires examination under general anesthesia. Operative endoscopy plays an essential role in allowing for a more precise localization of tumor extent and involvement of surrounding structures than can be achieved through imaging studies alone. Integration of the surgeon's office and intra-operative examinations with the radiographic evaluation allows for the complete assessment of the extent and stage of the cancer. The surgeon then presents findings to the multidisciplinary tumor board where a collaborative decision regarding the most appropriate initial therapy is made.

For each clinical presentation, a multidisciplinary decision regarding optimal therapy should be made between the head and neck surgeon, radiation oncologist, and medical oncologist. Although the majority of patients with advanced laryngeal and pharyngeal carcinomas are considered appropriate candidates for combined chemoradiation therapy, there are selected patients in whom primary surgical management is considered to be more appropriate. For example, advanced laryngeal and pharyngeal tumors with pre-treatment characteristics predicting a poor response to chemoradiation may be considered for up front surgical resection. In addition, patients who have had prior radiation therapy to the head and neck or those in which other medical problems limit the use of chemotherapeutic agents may also be considered surgical candidates.

Surgery remains the primary treatment modality for carcinoma involving the oral cavity, with the addition of postoperative radiation therapy (+/- chemotherapy)
depending upon tumor characteristics. In addition, early stage pharyngeal and laryngeal carcinomas with limited neck nodal disease may be reasonable candidates to consider primary surgery with selective neck dissection, followed by post operative radiation therapy.

For patients with large tumors encroaching on the airway, tracheostomy may be considered prior to beginning therapy to avoid precipitous airway obstruction which can occur during therapy. In cases where airway observation is sufficient, planned surveillance with appropriate follow-up evaluations during chemoradiation therapy is initiated. Examination of the primary site and neck nodal disease allow the surgeon to assess the tumor's early response to therapy. In cases with poor response to chemoradiation early preparation for possible surgical intervention can be initiated.

An essential role of the head and neck surgeon is to assess the patient's tumor status following the completion of chemoradiation therapy. The surgeon may coordinate the timing of post-treatment imaging including CT scan, MRI and PET. Integration of imaging with clinical exam findings will allow the surgeon to decide whether additional biopsies of the primary site are necessary. For the majority of patients with a complete locoregional tumor response to chemoradiation therapy, the surgeon will play a role in the continued surveillance of the patient, in coordination with the radiation oncologist and medical oncologist. In the event of a positive finding, decisions regarding salvage surgery, extent of resection, and reconstructive options must be made.

The Radiation Oncologist

Radiation therapy plays an important role in both definitive (initial, curative) and adjuvant treatment (treatment in the absence of definable disease when there is still a significant chance of microscopic disease) of head and neck squamous cell carcinoma as we have noted above. Understanding the complex anatomy in relation to normal physiology and in terms of patterns of cancer spread is of paramount importance to the treatment decision process.

The radiation consultation involves a thorough clinical evaluation including prophylactic management to minimize side effects. In some cases, avoidance of long term dental and oral complications involves careful planning and coordination with an oral surgeon. For example, pre-therapy dental care can prevent osteoradionecrosis, a severe late complication of the mandible in which there is death of bone tissue. A fabricated bite-block can allow separation of mucosal surfaces (the tissue lining of mouth structures) and absorb backscatter from dental fillings, minimizing mucositis (inflammation of the lining structures). Long-term dental follow-
up optimizes oral hygiene. Consideration of a feeding tube is important due to the risk of weight loss during treatment which can result from mucositis and poor oral intake.

Inverse planned intensity modulated radiation therapy (IMRT) has had a major impact in the treatment of head and neck cancers. This radiation technique allows for more precise control of dose distributions, facilitating the sparing of critical structures adjacent to areas of disease. Quality of life studies and objective measurements, such as salivary flow, have demonstrated improvement with the use of this technology over older radiation techniques.

Initially, IMRT was used to minimize dose to the parotid glands to avoid late xerostomia (dry mouth), which has a significant impact on swallowing, taste, and oral hygiene. It is clear that sparing these glands to certain thresholds of radiation allows long-term improvement in stimulated and non-stimulated salivary flow. Newer studies show that dysphagia (difficulty swallowing), mucositis (inflammation of the tissues of the mouth), and skin toxicity can be minimized safely by sparing additional structures. Severe complications such as osteoradionecrosis (radiation induced bone death) or temporal lobe (brain) atrophy have become exceedingly rare.

Radiation dose also has a significant impact on cure rates. IMRT has facilitated dose escalation in a safe manner as demonstrated in multiple studies. IMRT also facilitates re-irradiation as salvage treatment when necessary.

Due to the complexity of IMRT, an extensive quality assurance evaluation takes place to ensure calculated and expected values are concordant. The patient is immobilized using a personalized plastic “mask” to ensure accurate and reproducible delivery of treatment. Proper positioning during therapy is verified frequently.

Image guided radiation therapy represents the next technological frontier. By visually tracking changes that occur during radiation therapy, one can intelligently modify the radiation plan to account for anatomic changes related to tumoral response or weight loss. Published studies show this is significant in terms of proper radiation dose delivery to the target and sparing of critical structures. More importantly, it may allow us to “push the envelope” with dose escalation. New studies show sparing of additional structures is feasible and results in diminished side effects.

During the course of treatment, the patient’s side effects are carefully monitored. Patients are encouraged to maintain proper caloric and fluid intake, and daily weights are tracked. Newer agents, both topical and systemic, have been shown to reduce xerostomia and mucositis. Following treatment, close clinical follow up continues. Physical rehabilitation can maximize neck range of motion and minimize soft tissue fibrosis (loss of elasticity). Long term clinical monitoring for recurrence is undertaken by all members of the treatment team.

The Medical Oncologist

Chemotherapy often plays a crucial role in optimizing patient survival and quality of life as we have discussed above. However, traditional chemotherapy agents can be very toxic and most patients arrive in our office with terrible preconceived notions of the horrors of chemotherapy. Fortunately, we can often dispel these fears and offer patients reassurance in regard to their ability to tolerate chemotherapy thanks to recent advances in chemotherapy itself and the supportive care drugs available to us.

Cisplatin is a traditional chemotherapy drug that has been used for decades. It is very effective in head and neck cancers on its own but also in its role as a radiation sensitizing agent (it makes tumors more vulnerable to the therapeutic effects of radiation). Cisplatin can cause severe nausea, vomiting, fatigue and taste alteration. It can result in hearing loss, kidney failure and low blood counts which in turn can be life-threatening. As frightening as that sounds we rarely see any of these
side effects anymore. In the last 5 years, a number of very potent anti-nausea medications have made significant stomach upset a rare event. We have excellent monitoring and dose adjustment schema developed to minimize kidney and blood toxicity and several medications to help boost blood counts and avoid dangerous situations.

No matter how experienced and careful the medical oncologist, there remains the potential for considerable toxicity with traditional chemotherapy. This fact has driven the development of novel targeted therapies which are drugs developed to take advantage of cancer’s molecular vulnerabilities. The most developed targeted therapy in head and neck cancer is the epidermal growth factor receptor antibody, Cetuximab. This agent does not have any of the traditional chemotherapy toxicities and in fact, has few of its own (one being rash). When combined with radiation in certain head and neck cancers it increases survival by about a third without increasing clinically significant toxicity over that of radiation alone.

Recent and ongoing clinical trials offer us new drugs and drug combinations that are effective in head and neck cancers with better patient tolerance, but the battle is far from over. Head and neck cancers are morbid and potentially fatal diseases. Depending on the site involved, the stage of the cancer, the patient’s co-morbidities and the patient’s personal preferences, treatment options can be a myriad. A team of experienced experts is crucial in navigating this field and we offer just that team at Swedish/Edmonds. We are committed to seeing our patients through this terrible ordeal with the best quality and quantity of life possible.
## Community Services

### Diagnostic Services
- Radiology
- MRI/CT Scanner
- Mammography/Ultrasound
- Laboratory/Pathology
- Sentinel Lymph Node Biopsy
- PET/CT Scanning (Swedish/Edmonds)

### Treatment Planning
- Weekly Tumor Board
- Weekly Care Conference
- Weekly Breast Cancer Conference

### Survivorship Programs
- Look Good Feel Better Classes
- Reach to Recovery
- Breast Cancer Support Group Referral
- Cancer Support Group Referral
- I Can Cope (Free Online Classes)
- Free Wigs/Fittings

### Treatment
- Oncology Surgery
- Chemotherapy (Puget Sound Cancer Centers)
- Radiation Therapy (Swedish Cancer Institute at Swedish/Edmonds)
- Inpatient Services
- Outpatient Services
- Pain Management
- Physical Therapy
- Occupational Therapy
- Lymphedema

### Supportive and Continuing Care Services
- Clinical Nutrition
- Social Services
- Speech
- Respiratory
- Cardiology
- Neurology

- Coordination with Home Health & Hospice
- Bereavement Program
- American Cancer Society Resource Center Including the Road to Recovery and Patient Lodging Programs

## Free Community Programs

### Want to Quit Smoking Program
Helpful guidelines for quitting as well as information on the use of tools like nicotine patches and gum.

### Bereavement Support Group
Includes support groups, luncheons, service of remembrance and a lending library as opportunities for assistance in the grief process. Staffed by professional bereavement coordinator, hospital chaplains and trained volunteers.