Even in the dappled sunlight of a Northwest forest, we still need sunblock to protect our skin.

Southwest’s Regional Cancer Center is a guiding compass throughout our patients’ journeys with cancer.
FREE Cancer Center DVD:

Meet the surgery, radiation, and chemotherapy experts at Southwest, who describe the latest techniques in cancer treatment. Learn how our nurse navigators can guide patients and their families through their journey with cancer. See Curtis, who rides his Harley while receiving chemotherapy, and Jim, a Navy vet who’s fought his cancer battle with CyberKnife® radiosurgery treatment. Request a free, 6-minute Cancer Center DVD (while supplies last) at www.swmedicalcenter.org/DVD.
## Executive Summary:

Cancer Care: More than Skin Deep .................................................. 1

Donna Feild, RPh, MBA  
Co-Chair, Cancer Committee; Administrative Director, Regional Cancer Center and Pharmacy

## Site Review:

Common Skin Cancers: The ABCDEs of Detection ......................... 3

Theresa Mah, DO, The Vancouver Clinic Dermatology  
Zheng Qian, MD, PhD, The Vancouver Clinic Dermatology

The ABCDE Signs of Identifying Skin Lesions for Melanoma ............. 5
Risk Factors: Nonmelanoma Skin Cancers ...................................... 5
Age at Diagnosis of Melanoma — Southwest 2007 .......................... 6
Age at Diagnosis of Melanoma — National 2007 ............................. 6
10-Year Melanoma Incidence — Southwest .................................... 7
AJCC Pathologic Stage Grouping .................................................. 7
Stage at Diagnosis — Southwest vs. National ............................... 8
Melanoma First Course Treatment — Southwest 2007 ..................... 8
Treatment for Melanoma — Surgical Margins ............................... 8

Adjuvant Therapy: Interferon and Other Treatments ..................... 9

Lewis M. Steinberg The Vancouver Clinic Hematology/Oncology

Radiation Therapy for Skin Cancers: Alternatives to Surgery .......... 11

Carol M. Marquez, MD, Southwest Radiation Oncology/CyberKnife®

5-Year Survival Comparison — Melanoma —  
Southwest vs. National Oncology Database .................................. 12

5-Year Survival Comparison by Stage — Melanoma ....................... 12

## Clinical Research:

Our Commitment to Clark County .............................................. 13

Rebecca Hambright, RN, OCN, CCRP, Cancer Research
Support Services:
Free Community Skin Cancer Screening ................................. 14
Chris O’Hara, RN, BSN, OCN, Nurse Navigator/Oncology Nurse Coordinator

Skin Cancer Prevention:
Community Outreach to Teens and Adults ............................... 15
Gail Helland, RN, BS, Nurse Navigator/Oncology Nurse Coordinator

Cancer Registry:
Tracking for Extraordinary Care, Not Just Data ......................... 16
Marie Tesdale, RHIT, CTR, Lead Cancer Registrar

Southwest Cancer Incidence Data — 2007
10-Year Cancer Incidence — Southwest 1998–2007 ...................... 17
Comparative Cancer Incidence — 2007 ................................. 17
Southwest Regional Cancer Center Primary Site Table — 2007 ........ 18
Southwest Frequency of Cancer by Gender — 2007 .................... 19
Southwest Major Cancers — Stage at Diagnosis 2007 ................. 19

About Southwest Washington Medical Center:
Comprehensive Cancer Care at Southwest: Summary of Services ....... 20
Cancer Committee Members 2008 ........................................ 23
Map to Comprehensive Cancer Services at Southwest Washington Medical Center. .................................. Back Cover
Executive Summary:

Cancer Care: More than Skin Deep
Donna Feild, RPh, MBA
Co-Chair, Cancer Committee; Administrative Director, Regional Cancer Center and Pharmacy
www.swmedicalcenter.org/CancerCenter

More than 1 million cases of basal cell and squamous cell carcinomas occur in the United States annually. Most of these forms of cancer are highly curable. The most serious form of skin cancer, melanoma, was diagnosed in approximately 60,000 persons in the U.S. in 2007. Unfortunately, Clark County has one of the highest annual death rates for persons with melanoma, according to the most recent data from the National Center for Health Statistics.

Understanding that the citizens of Clark County are experiencing a rising trend in melanoma-related death leads us to ask, “What can we do to help?” The answer to this question is really a list of things:

First, educate the people of Clark County about how to prevent skin cancers.
- Avoid midday sun exposure, wear hats and sunglasses and sunscreen, and avoid tanning beds.
- Look for changes in size, shape or color of skin lesions.

In 2007, the Regional Cancer Center’s outreach program provided cancer-related education to over 9,600 people in Clark County. In 2008, the Regional Cancer Center distributed more than 2500 sunscreen packets over the summer months in order to help raise awareness of skin cancer prevention. Convincing people to follow simple prevention guidelines is half of the battle.

The other piece of the battle against skin cancer is treatment.

For many years now, the Regional Cancer Center has sponsored an annual skin screening clinic for the citizens of Clark County. This year 24 individuals who attended the screening were found to have suspicious skin lesions and were referred for followup care.

While most skin cancers are curable, many people still die of melanomas. Participation in research studies, whether for treatment of melanoma or for any cancer, is another way to fight this battle. Research has played a major part in cancer treatment at the Regional Cancer Center. The first patient put on a research trial at Southwest was in 1986. She is still alive today!

We currently have over 80 research trials open for all types of cancers at Southwest. The number of patients referred to our cancer research nurses for evaluation of eligibility for these trials has quadrupled over the past 3 years. We are playing a significant part in finding cures for different
cancers and improving the lives of our cancer patients by making research trials available to them.

Our annual report describes current findings about melanoma and what Southwest has accomplished this year to fight cancer. As you learn the facts and figures, think about the people you know who have been or could be affected by skin cancer:

• The teenager who’s determined to get a tan before the prom
• The Northwest native who believes our cloud cover is sufficient protection from the sun
• The balding grandparent who forgets to wear a hat

You can help.

As a not-for-profit institution, we provide health services for every person who comes to us, regardless of their ability to pay. But we can’t do it alone. Gifts to the Southwest Foundation’s Cancer Center fund can change lives. For example:

• Researching cancer prevention and treatment options
• Testing methods to control cancer-related nausea and vomiting
• Participating in quality of life studies, such as relaxation studies during chemotherapy

Purchasing equipment and training staff for clinical studies

• Funding research studies performed at Southwest
• Supporting our genetic testing and counseling program
• Helping to fund support groups and other activities for cancer survivors
• Expanding educational outreach

To make your gift to the Cancer Center, contact Southwest’s Foundation (360.514.3106 or www.swdonate.org). Or, contact the Regional Cancer Center at 360.514.2174. We invite you to make a difference and support our mission.

Not So Fun Facts:

• More than 1 million new cases of skin cancer will be diagnosed in the US this year.
• 1 in 5 Americans will develop skin cancer in their lifetime.
• Melanoma is the most common form of cancer for young adults age 25-29.
• More than 75 percent of skin cancer deaths are from melanoma.
• Melanoma is increasing faster in females 15-29 years old than males in the same age group.
• One American dies of melanoma every 62 minutes.
Skin cancer is becoming an increasing health concern. The incidence of skin cancer continues to rise over the last few decades. The increase in incidence is attributed to the combination of cumulative photo damage related to increased sun exposure associated with social, occupational, and lifestyle trends, and cutaneous immunosuppression associated with aging. Skin cancer is the most common cancer, but fortunately, it is often easily curable with appropriate treatment when recognized and detected early.

Nonmelanoma skin cancer accounts for the vast majority of skin cancers, with an estimate of over 1 million new cases reported in 2008 in the US. Nonmelanoma skin cancers include most commonly basal cell carcinomas and squamous cell carcinomas, with basal cell carcinomas by far the most common occurring in a ratio of 4:1. Although many other skin cancers also occur, these two cancers and melanoma will be the main focus in this article.

“85% of basal cell carcinomas occur on the head and neck, with 25-30% of these occurring on the nose.”

Prevention

Methods to help prevent skin cancer are simple:

- Limit unprotected sun exposure especially between 10 a.m. and 4 p.m.
- Use daily sunscreen SPF 15 or higher that contains UVA and UVB protection.
- Wear protective clothing and broad rimmed hat.
- Recommend monthly self skin examination. Educate patients in ABCDEs signs of melanoma is helpful in that regard.
- For patients over age 40 and those with prominent risk factors, recommend annual skin examination for skin cancer surveillance.
- Avoid the use of tanning beds.

BCCs: Genetics and Cumulative Sun Exposure with Resultant Gene Mutations

Basal cell carcinomas are fibro epithelial malignancies most likely derived from epidermal basal cells and germinative cells of appendageal structure. The etiology of these basal cell carcinomas is related primarily to genetic makeup and chronic cumulative sun exposure with resultant gene mutations in patched and components in sonic-hedgehog pathway.

Mutations in P53 are also commonly found in basal cell carcinoma. In general, these neoplasms develop in sun exposed areas and in areas where pilosebaceous units are more dense, i.e., face. In fact, 85% of BCCs occur on the head and neck, with 25-30% of these occurring on the nose.
Twenty percent (20%) occur in non-sun exposed areas.

There are several clinicopathologic variants of basal cell carcinomas:

- Nodular
- Superficial multicentric
- Cystic
- Pigmented
- Infiltrative or micronodular
- Morpheaform
- Fibroepithelioma of Pinkus

Among them, the most common is the nodular form, which appears as pinkish translucent papule with a pearly border, sometimes with ulceration. The more aggressive forms include infiltrative or morpheaform, which often has ill defined border and substantial subclinical spread.

Malignant SCCs: Genetics, Environmental Exposure, Chemical Carcinogens

Squamous cell carcinomas (SCCs) are malignant neoplasms arising from epidermal keratinocytes. Etiology is clearly multifactorial, involving both genetic predisposition and environmental exposures, but UV-induced gene mutations play a major role in its pathogenesis. Chemical carcinogens such as arsenic, viruses such as human papilloma virus (HPV) type 6, 11, radiation, chronic ulcers from injury and dermatitis, are also implicated in a subset of SCCs.

Loss of protection from P53 mutations are often seen in SCCs. Host immunity appears extremely important in fighting SCCs, as evidenced by high rates and aggressive behavior of SCCs in solid organ transplant recipients. Monitoring of these patients for skin cancer is certainly important in reducing morbidity and mortality.

Clinically, SCC overwhelmingly presents in sun-exposed areas, 70% on head and neck, but it can occur in many sun-shielded areas such as oral mucosa, and genital areas. Early SCCs often are flat and have a rough adherent scale. As it grows in size, it may form firm and nodular growth, cause ulceration and pain. Most SCCs grow in months and years, but the keratoacanthoma subtype can grow rapidly over several weeks, then involute over months and years.

“The most common form [of basal cell carcinomas] is the nodular form.”

“Squamous cell carcinomas [involve] ... both genetic predisposition and environmental factors, but UV-induced gene mutations play a major role.... Chemical carcinogens are also implicated in a subset of SCCs.”
Malignant Melanoma: Serious and Potentially Fatal

Malignant melanoma is a serious and potentially fatal skin cancer. It accounts for 4% of all skin cancers and 73% of skin cancer-related deaths. In the US during 2008, it is estimated that approximately 62,480 new cases of melanoma will be diagnosed with 8,420 reported melanoma-related deaths.

The pathogenesis of melanoma is not entirely elucidated yet, although several genes (CDKN2A, CDK4, p14) have been identified in familial melanomas. The identification and diagnosis of early melanomas is important in reducing morbidity and mortality.

Clinically, the ABCDE signs are helpful in identifying skin lesions suspicious for melanoma.

### The ABCDE Signs of Identifying Skin Lesions for Melanoma

| A | Asymmetry | One half unlike the other half |
| B | Border Irregularity | Irregular, scalloped, or poorly circumscribed borders |
| C | Color Variation | Varied from one area to another; shades of tan, brown, black, and sometimes white, red, or blue |
| D | Diameter | Lesions larger than 6mm; increasing diameter |
| E | Evolution | Change of the lesion over time |

### Risk Factors: Nonmelanoma Skin Cancers

Individuals with fair complexion, red hair, light colored eyes have the highest risk.

<table>
<thead>
<tr>
<th>Type</th>
<th>Skin color</th>
<th>Sunburn and tanning history</th>
<th>Skin cancer risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Pale white</td>
<td>Burns easily, never tans</td>
<td>highest</td>
</tr>
<tr>
<td>II</td>
<td>White</td>
<td>Burns easily, minimally tans</td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>White</td>
<td>Burns moderately, tans moderately</td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>Beige, light tan</td>
<td>Burns minimally, tans easily</td>
<td></td>
</tr>
<tr>
<td>V</td>
<td>Moderate brown</td>
<td>Rarely burns, tans profusely</td>
<td></td>
</tr>
<tr>
<td>VI</td>
<td>Dark brown, Black</td>
<td>Never burns, tans profusely</td>
<td>lowest</td>
</tr>
</tbody>
</table>

### Risk Factors: Cumulative Sun Exposure

- This results in cumulative photodamage which in turn results in mutations in: (1) P53 gene, which interferes the ability of abnormal cells to undergo apoptosis, and (2) patched gene, a tumor suppressor gene.
- Chronic UV radiation can induce DNA damage through formation of pyrimidine dimers.

### Risk Factors: Intrinsic Aging

- With aging there is cutaneous immunosuppression. Langerhan cells play a role in cell mediated immunity. The diminished number of Langerhan cells related to aging and UV radiation exposure likely results in tumor permissiveness.
- Incidence increases markedly after age 40.
Risk Factors: Immunosuppression

- Iatrogenic (internal: CLL, AIDS or external: medication related organ transplant patients) or congenital (xeroderma pigmentosa)

- The longer the duration and more intense levels of immunosuppression, the greater the risk of skin cancer development. With immunosuppression, the risk for developing SCC is significantly higher than the risk for developing BCC.

- Transplant patients have an increase risk of 65 fold for SCCs and 3 fold increase for melanoma.

- Among solid organ transplant patients, there is a 2-3 times greater risk in developing SCCs with heart transplant patients than renal transplant patients; while liver transplant patients have the lowest risk.

Risk Factors: Sunburns

A history of blistering sunburns as a child is a risk factor (mainly for squamous cell carcinoma).

Risk Factors: Previous Injury (mainly for squamous cell carcinoma)

- Radiation exposure
- Burns
- Scars
- Chemical carcinogens: arsenic, lubricating oils, paraffin, anthralin, and topical hydrocarbons

Risk Factors for Malignant Melanoma

- Light colored skin
- Chronic cumulative sun exposure and history of blistering sunburns
- Numerous nevi (>50)
  Melanoma risk increases with higher mole counts. Mole counts are determined by degree of sun exposure during childhood, skin type, and genetics.

Congenital Large or Giant Nevi

- These nevi are rare occurring in less than one in 20,000 infants.

- Size exceeds 20 cm and most commonly occur on the trunk but can occur anywhere. One-fourth of these children with giant congenital nevi overlying head or spine will have neurocutaneous melanosis, melanocytic proliferation within the leptomeninges and brain parenchyma.

- Estimated risk of melanoma is approximately 5-15% and can arise for the nevus itself or from extracutaneous sites, i.e., CNS.
History of Atypical Nevi

Family history of melanoma: one or more first degree relative with melanoma

Approximately 10% of melanomas are associated with familial or inherited syndromes. Three genes have been identified: CDKN2A, CDK4, and P14.

Diagnosis

Diagnosis of skin cancers is based on clinical presentation and histological evaluation. Biopsy remains a key method in diagnosing and confirming skin cancer. The type of biopsy done, whether it is a shave, punch, or excisional, depends on the clinical differential and patient consideration.

The goal is to provide the necessary tissue to establish and confirm diagnosis and at the same time with minimal morbidity and scarring. The information obtained from biopsy allows for staging workup and selection of appropriate treatment modality.

“**The goal [with biopsy] is to provide the necessary tissue to establish and confirm diagnosis and at the same time with minimal morbidity and scarring.**”

Staging of Melanoma

Here is the American Joint Committee on Cancer (AJCC) staging classification by groups.

<table>
<thead>
<tr>
<th>AJCC Pathologic Stage Grouping *</th>
<th>Tis</th>
<th>N0</th>
<th>M0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage IA</td>
<td>T1a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IB</td>
<td>T1b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage II A</td>
<td>T2a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIA</td>
<td>T2b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIB</td>
<td>T3b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIC</td>
<td>T4a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage III A</td>
<td>T1–4a</td>
<td>N1a</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIIA</td>
<td>T1–4a</td>
<td>N2a</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIIB</td>
<td>T1–4b</td>
<td>N1a</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIIC</td>
<td>T1–4b</td>
<td>N2a</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IV</td>
<td>Any T</td>
<td>Any N</td>
<td>M1</td>
</tr>
</tbody>
</table>

This is the stage at diagnosis at Southwest compared to national statistics.

<table>
<thead>
<tr>
<th>Stage at Diagnosis</th>
<th>Southwest</th>
<th>vs. National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 0</td>
<td>38%</td>
<td>20%</td>
</tr>
<tr>
<td>Stage I</td>
<td>47%</td>
<td>36%</td>
</tr>
<tr>
<td>Stage II</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Stage III</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Stage IV</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Treatment for Nonmelanoma

Treatments for nonmelanoma skin cancers depend on clinicopathological characteristics, patient preference and co-morbidity, and available resources. Surgical removal such as excision and Mohs surgery are the mainstay, while in selected patients and locations, topical therapy with imiquimod, cryotherapy, electrodessication and curettage and radiation are good options. The goal is to remove the skin cancer in its entirety while at the same time achieving optimal cosmetic results.

For skin cancers on head and neck, large or aggressive skin cancers, Mohs surgery is indicted as it offers high cure rate and minimal tissue loss.

### Nonmelanoma Treatments:
**Surgery or topical therapy**

### Melanoma Treatments:
**Surgery, lymphatic mapping with sentinel lymph node biopsy**

It relies on examination of the 100% margin of the freshly excised tissue, and reconstruction of the resultant wound, usually on the same day.

Treatment for Melanoma

The cornerstone of treatment for melanoma is surgical excision with margins based on Breslow thickness, as the prognosis is directly related to the thickness of melanoma. These are the current accepted recommendations for surgical margins for melanoma:

<table>
<thead>
<tr>
<th>Surgical Margins</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In situ</td>
<td>0.5 cm</td>
</tr>
<tr>
<td>&lt; 1 mm</td>
<td>1.0 cm</td>
</tr>
<tr>
<td>1.01- 4 mm</td>
<td>2.0 cm</td>
</tr>
<tr>
<td>&gt; 4 mm</td>
<td>≥ 2.0 cm</td>
</tr>
</tbody>
</table>

These recommended margins may vary with anatomical location. Several studies suggested that in many cases, 0.5cm may not be sufficient for melanoma in situ, so modified Mohs surgery and staged excision have been used for better margin control.

Lymphatic mapping with sentinel lymph node biopsy has become an increasingly common procedure to identify regional nodal metastasis for melanomas greater than 1 mm in Breslow thickness. Currently, this is primarily a staging and prognostic tool with no proven therapeutic value or survival benefit. Patients with positive sentinel lymph node biopsy will typically undergo complete lymphadenectomy of affected lymph node basin.

Although interferon therapy has been shown in initial studies to improve disease-free survival in a subset of late-stage patients, its routine use remains controversial. (For additional information, refer to Adjuvant Therapy in this annual report, which follows.)

Despite the various chemotherapy and immunotherapy available, the prognosis for patients with advanced melanomas remains poor. For that reason, efforts to reduce morbidity and mortality continue to be focused on prevention, early detection and treatment.
Adjuvant Therapy:

Interferon and Other Treatments

Lewis M. Steinberg, MD
The Vancouver Clinic Hematology/Oncology
www.swmedicalcenter.org/FindDoc

The role of adjuvant interferon alpha (IFN) in patients at high risk for relapse (stage IIB or IIC) remains controversial. Trials published over the past 12 years through ECOG and the intergroup mechanism have uniformly demonstrated an improvement in relapse free survival (RFS). However, these same trials and subsequent meta-analyses have not clearly demonstrated a survival benefit (1).

The toxicity of the high dose INF used in these trials is substantial (bone marrow, liver, CNS and thyroid). Therefore, the decision to offer IFN to high risk patients requires an understanding on the part of the physician and patient that treatment may not improve survival whereas marked alteration in quality of life is nearly certain.

In spite of many years of testing, vaccine therapy has yet to be approved for use in this setting. This includes cellular vaccines, defined antigen vaccines and GM-CSF. Clinical trials continue to investigate IFN, vaccines and bio-chemotherapy.

Advanced Disease: Cytotoxic Chemo and Bio-chemotherapy

Dacarbazine is the only approved chemotherapy agent for use in the advance setting. It has modest single agent activity and mild to moderate toxicity. Although not yet approved for this indication, Temozolomide has been compared to Dacarbazine and demonstrated non-significant improvements in progression-free survival (PFS), survival and quality of life (2). It has the advantage of oral administration and penetration into the central nervous system.

Other chemotherapy drugs with single agent activity include platinum, nitrosoureas, and microtubule inhibitors (i.e., Vinblastine, Paclitaxel). There is no convincing evidence that a combination of chemotherapy agents (with or without Tamoxifen) provide an improvement in PFS or overall survival.

The use of chemotherapy in combination with IFN and/or IL-2 in the advanced setting has not led to improvements in survival and is not recommended outside of a clinical trial. Sorafenib (tyrosine kinase inhibitor) and Oblimersen (antisense oligonucleotide) are undergoing testing in combination with chemotherapy.

Interleukin -2 (IL-2) and IFN

High dose bolus IL-2 remains the only therapy with curable potential in the advanced setting. With almost 20 years of clinical experience with IL-2, it has been determined that approximately 15% of patients will achieve a partial or complete remission. Within this responding group, a further subset of patients will enter a period of sustained remission and cure.
Unfortunately, there is not a reliable way to predict which patients will derive a benefit from IL-2. This is a particularly important point in view of the substantial toxicity of IL-2 with induction of a sepsis-like state (and multisystem effects) necessitating treatment in an ICU under the direction of experienced physicians.

IFN has limited clinical activity as a single agent and has been used for palliation. The availability of pegylated IFN has lessened the toxicity of this therapy.

Experimental

The targeting of the CTLA4 receptor on T lymphocytes using a monoclonal antibody approach is under intense investigation. Data published by the NCI (3) was notable for the extremely durable responses seen in a minority of patients treated with the monoclonal antibody Ipilimumab. Similar findings with Ipilimumab were published in abstract form at ASCO 2008.

Summary

Significant advances in the systemic treatment of melanoma have not occurred since the introduction of INF (adjuvant setting) and IL-2 (advanced setting). These therapies remain toxic and appear to benefit only a limited subset of patients. The promise of vaccine therapy has not been substantiated based on the results of clinical trials. Chemotherapy continues to have a limited role in palliation. Newer approaches in systemic therapy are clearly needed to advance the field.

1. Does adjuvant interferon-alpha for high-risk melanoma provide a worthwhile benefit? A meta-analysis of the randomized trials. AU Wheatley K; Ives N; Hancock B; Gore M; Eggermont A; Suciu S SO Cancer Treat Rev 2003 Aug;29(4):241-52

2. Randomized phase III study of temozolomide versus dacarbazine in the treatment of patients with advanced metastatic malignant melanoma. AU Middleton MR; Grob JJ; Aaronson N; Fierlbeck G; Tilgen W; Seiter S; Gore M; Aamdal S; Cebon J; Coates A; Dreno B; Henz M; Schadendorf D; Kapp A; Weiss J; Fraass U; Statkevich P; Muller M; Thatcher N SO J Clin Oncol 2000 Jan;18(1):158-66

3. Prognostic Factors Related to Clinical Response in Patients with Metastatic Melanoma Treated by CTL-Associated Antigen-4 Blockade. AU Downey SG; Klapper JA; Smith FO; Yang JC; Sherry RM; Royal RE; Kammula US; Hughes MS; Allen TE; Levy CL; Yellin M; Nichol G; White DE; Steinberg SM; Rosenberg SA SO Clin Cancer Res. 2007 Nov 15;13(22):6681-8. Epub 2007 Nov 2
Surgery is the primary modality for the treatment of the majority of skin cancers. However, radiation therapy is a useful treatment for those skin cancers that are incompletely removed or whose removal would cause significant cosmetic deformity. Radiation therapy may also be used in those patients with certain special types of skin cancers where spread to lymph nodes is common. In all of these situations, it is important for the dermatologist and the radiation oncologist to communicate about the goals of treatment and the coordination of care.

**Using Radiation to Avoid More Extensive Surgery**

Most basal and squamous cell carcinomas of the skin can be completely resected. When a complete resection is not possible or when there is a small residual amount of cancer left at the edges of the resection, radiation therapy can be given to that area to prevent a recurrence of the original cancer. By giving the radiation, a more extensive surgery is avoided.

There are also locations where a complete resection of the primary tumor will cause a cosmetic deformity. Locations where this is seen include around the eyes, the nose or the lips.

Radiation therapy can be delivered to small basal cell or squamous cell carcinomas in these locations without any surgery and will produce an excellent cosmetic result. In this situation, the radiation is delivered over six to seven weeks so that the long term scarring is minimized.

**Using Radiation for Skin Cancer Commonly Spread to Lymph Nodes**

There are certain types of skin cancer that more commonly spread to lymph nodes. Two examples of this are malignant melanoma and Merkel cell carcinoma. In certain situations when the risk of lymph node involvement is high, radiation therapy will be given to the draining lymph nodes to prevent a local recurrence in that area and to kill the tumor cells that may have spread to the regional nodes. This type of treatment may be given after a surgery has been performed to evaluate the status of the nodes.

If the lymph nodes are enlarged at the beginning, then surgery is usually done to remove those enlarged nodes. These are two less common types of skin cancer, but the appropriate management of them is important when the goal of treatment is curative.

Radiation therapy has been an important tool in the curative approach to skin cancers since X rays were discovered over 100 years ago. Radiation can be used in all types of skin cancer and in many different clinical settings. Again, coordination of care is essential for these patients.

*Behind the scenes in Southwest’s Radiation Oncology/CyberKnife® center, Cathi Agard (dosimetrist) and Calvin Chan (physicist) are part of the team that carefully designs individual radiation treatment plans for Southwest’s cancer patients.*
Compared to national data, Southwest patients tend to have a higher 5-year survival rate for melanoma.

Southwest's patients follow national trends: When melanoma is diagnosed and treated in earlier stages, the percentage that survives is significantly higher.
Southwest Washington Medical Center has been involved in cancer research for more than 20 years. Over that time, we have seen many skin cancer studies open and close.

A Commitment Both Local and International

Recently we have had two studies for melanoma, one for advanced melanoma and the other for early-stage melanoma. Both studies used various Interferon dosing regimens to treat melanoma, and they reached their accrual goals before closing early this summer.

As of Fall 2008, Southwest has a new Phase II trial being opened for metastatic melanoma. (Phase II trials reveal how well the new treatment works and also determine side effects.) This study uses new drugs in the melanoma fight: Sorafenib plus either Temsirolimus or Tipifarnib. All of these medications are new targeted therapies being studied for the first time in melanoma. This Phase II trial comes to us from Southwest Oncology Group through the Columbia River Oncology Program, a community research cooperative supported by Southwest Washington Medical Center.

We are also looking at an industry-sponsored vaccine study for melanoma. At this time, the study has not received final approval to open, but Southwest may be one of the first international sites to open once we receive the green light.

“A Lifetime Partnership with Patients

Southwest has been involved in cancer research since 1986. Today we still follow the first patient put on a study, and we are happy to report that our patient remains disease-free.

Many patients are followed for their lifetime when they enroll in a clinical trial. Others often opt for additional treatment on a clinical trial after completing their first study.

Our commitment to the patients of Clark County is one huge reason why we constantly search for clinical trials that meet the needs of our community. Skin cancer is becoming more and more common here in the Pacific Northwest, and as our population ages, the need for research will only increase.
Every year since 1989, Southwest Washington Medical Center has provided free community skin cancer screenings to the residents of Clark and Skamania Counties. As a member of the American Academy of Dermatology, Joel Datloff, MD has served as the Regional Cancer Center’s program director for the community screening.

2008 Screening Clinic Identifies 24 Cases

To assist with the screening on June 21, 2008, Dr. Datloff recruited three of his fellow colleagues: Zheng Qian, MD, PhD; Theresa Mah, DO; and Henrik Martens, MD. With the assistance of six volunteers from the Regional Cancer Center, the physician team screened 146 patients over a four hour period. This year 24 presumptive diagnoses of skin cancer were identified:

- 19 basal cell carcinoma
- 4 squamous cell carcinoma
- 1 melanoma

These 24 individuals were instructed to follow up with a dermatologist for further diagnostic testing, staging and treatment.

As each person exited the free skin cancer screening clinic at Same Day Medical, the oncology nurse coordinator provided education information on how to prevent and identify skin cancer. As part of Southwest’s Pioneers in Cancer Care outreach, each person also received a free set of SPF30 sunscreen packets to help prevent skin cancer.

Skin Cancer Data Increases Since 1989

Since 1989 Southwest’s Regional Cancer Center has screened 1,984 people in the community for skin cancer. Of these, 230 presumptive diagnoses of skin cancer have been identified:

- 120 basal cell carcinoma
- 55 squamous cell carcinoma
- 55 melanoma

Southwest’s goal is to increase awareness of skin cancer and to promote prevention and early detection.

June 21, 2008: Free Skin Cancer Screening

4 dermatology expert physicians and 6 Regional Cancer Center volunteers at Southwest Washington Medical Center

146 patients screened for skin cancer over a 4-hour period

24 presumptive (preliminary) diagnoses of skin cancer

This year 146 individuals visited Southwest’s newly renovated Same Day Medical office to participate in the free skin cancer screening clinic. Southwest offers same-day procedures for urology, endoscopy, dental care, eye surgeries and interventional radiology.
Community outreach is an important objective of Southwest’s Regional Cancer Center. Every year, hundreds of people are given information to help them become more aware of cancer screening recommendations and cancer prevention facts.

Beauty is More than Skin Deep

Skin cancer prevention is an important component of presentations for all age groups. Several area high schools request a speaker to talk about cancer prevention every year, typically in the spring months. This usually correlates with the school’s prom date.

In 2007, 23 different talks were given to a total of 712 high school students in Clark County about cancer prevention, including skin cancer. Teenagers are becoming more aware of sun protection, but many are still tanning either with the sun or tanning beds. When asked about why they are tanning, most are stating a cosmetic purpose.

Many myths are still lurking among teens about sun protection. These myths range from getting a base tan to protect their skin, to the idea that if they tan easily they are not at risk of skin cancer. An encouraging sign is that every year, more teenagers come forward after the presentation and say that they are getting annual skin exams from a dermatologist.

Myths of Indoor Tanning

Indoor tanning remains a major risk factor for skin cancer in the United States. The American Academy of Dermatology (2008) lists several facts regarding indoor tanning on their website. More than 1 million people are using tanning beds every day in the United States. Every year, almost 30 million people use indoor tanning in the United States and 2.3 million of these are teenagers.

Besides the obvious risk of skin cancer, the use of tanning beds is also known to cause other serious health issues. These include:

- Cataracts
- Burns to the skin and eyes
- A weakened immune system
- Premature aging through the development of wrinkles and age spots

Expanded Community Outreach

More than 2500 packets of sunscreen were distributed to patients at the Regional Cancer Center and to Clark County residents at a wide range of community events throughout the summer of 2008, including:

- Free skin cancer screening clinic at Southwest Washington Medical Center
- Fourth of July celebration at Fort Vancouver
- West Clark County Relay for Life
- Battle Ground Relay for Life
- Clark County Fair
- Community health fairs

Outreach and education are important components to increase understanding of the dangers of tanning to young adults. Educating young adults about skin cancer may help change the perception that a tan equals beauty.
The Southwest Washington Medical Center’s Cancer Registry again accessioned over 1,200 new cancer cases for the year. This included cases diagnosed and/or treated at this facility for the year 2007. Registry activities also included monitoring and updating a database of over 24,000 cancer patients, case finding, abstracting and patient followup of all cases diagnosed or treated at our facility.

The data collected is reported to a variety of organizations, including the State Registry, National Oncology Database, and the National Cancer Database. Requested studies were provided to physicians, other allied medical providers, as well as hospital administrators, to evaluate outcomes, provide surveillance information, track survival rates, and to determine efficacy of treatment modalities for our patients.

Our Registry staff is also responsible for supporting a variety on monthly cancer conferences and acting as the hospital monitor of compliance with American College of Surgeons standards. All this is performed with the goal of continuing the Medical Center’s vision of exceptional medicine and extraordinary care for every person.

Skin Cancer’s Hall of Fame:
The Melanoma Research Foundation reports that someone in the US dies every hour from melanoma. It affects people of all ages, races, economic levels, and both sexes. Some famous people who have had melanoma or pre-cancerous lesions include:

- George H. W. Bush
- George W. Bush
- Johnny Carson
- Bill Clinton
- Sam Donaldson
- Dwight D. Eisenhower
- Bob Marley
- John McCain
- Regis Philbin
- Maureen Reagan
- Ronald Reagan
- Cybill Shepherd
- Elizabeth Taylor
- George Washington
Bar charts provide clear numbers, but they do not always convey the impact that cancer has on families. For example, during 2007 the number of cancer cases at Southwest was 1,229. Divide 1,229 cases by 365 days; this could mean that on any given day during 2007, in 3 or 4 families in Clark County, someone’s mother, father, sister, brother, child, or other loved one received the diagnosis of cancer.

Comparative Cancer Incidence — 2007

<table>
<thead>
<tr>
<th></th>
<th>Southwest</th>
<th>Washington State</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Site</strong></td>
<td>Number</td>
<td>Percentage</td>
<td>Number</td>
</tr>
<tr>
<td>Breast</td>
<td>265</td>
<td>22%</td>
<td>4,090</td>
</tr>
<tr>
<td>Lung/Bronchus</td>
<td>166</td>
<td>14%</td>
<td>3,970</td>
</tr>
<tr>
<td>Prostate</td>
<td>122</td>
<td>10%</td>
<td>5,000</td>
</tr>
<tr>
<td>Colorectal</td>
<td>115</td>
<td>9%</td>
<td>2,920</td>
</tr>
<tr>
<td>Melanoma</td>
<td>104</td>
<td>8%</td>
<td>1,630</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>57</td>
<td>5%</td>
<td>1,500</td>
</tr>
<tr>
<td>Bladder</td>
<td>53</td>
<td>4%</td>
<td>1,490</td>
</tr>
<tr>
<td>Kidney</td>
<td>35</td>
<td>3%</td>
<td>*</td>
</tr>
<tr>
<td>Ovary</td>
<td>29</td>
<td>2%</td>
<td>*</td>
</tr>
<tr>
<td>Uterus</td>
<td>28</td>
<td>2%</td>
<td>800</td>
</tr>
<tr>
<td>Other</td>
<td>255</td>
<td>21%</td>
<td>9,680</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,229</strong></td>
<td><strong>100%</strong></td>
<td><strong>31,080</strong></td>
</tr>
</tbody>
</table>

## Primary Site Table — 2007

<table>
<thead>
<tr>
<th>Primary Site</th>
<th>Number of case</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Cavity and Pharynx</td>
<td>18</td>
<td>1.5%</td>
</tr>
<tr>
<td>Tongue</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Salivary Glands</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Gum &amp; Other Mouth</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Tonsil</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Digestive System</strong></td>
<td><strong>178</strong></td>
<td><strong>14.5%</strong></td>
</tr>
<tr>
<td>Esophagus</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Stomach</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Small intestine</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Colon</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>Rectum and Rectosigmoid</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Anus and anal canal</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Liver</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Intrahepatic Bile Ducts</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Gallbladder</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Pancreas</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Other Biliary</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory System</strong></td>
<td><strong>171</strong></td>
<td><strong>13.9%</strong></td>
</tr>
<tr>
<td>Nasal cavity</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Larynx</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Bronchus and lung</td>
<td>166</td>
<td></td>
</tr>
<tr>
<td><strong>Bones and Joints</strong></td>
<td><strong>1</strong></td>
<td><strong>0.1%</strong></td>
</tr>
<tr>
<td><strong>Soft Tissue (including Heart and Mediastinum)</strong></td>
<td><strong>8</strong></td>
<td><strong>0.7%</strong></td>
</tr>
<tr>
<td>Skin excluding Basal &amp; Squamous</td>
<td>105</td>
<td>8.5%</td>
</tr>
<tr>
<td>Malignant melanoma – Skin</td>
<td>104</td>
<td></td>
</tr>
<tr>
<td>Other Non-epithelial Skin</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Breast</strong></td>
<td><strong>265</strong></td>
<td><strong>21.6%</strong></td>
</tr>
<tr>
<td>Female breast</td>
<td>264</td>
<td></td>
</tr>
<tr>
<td>Male breast</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Cervix</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td><strong>Breast, continued</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corpus uteri</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Ovary</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Vulva</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Other female genital</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Male Genital System</strong></td>
<td><strong>131</strong></td>
<td><strong>10.8%</strong></td>
</tr>
<tr>
<td>Prostate</td>
<td>122</td>
<td></td>
</tr>
<tr>
<td>Testis</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Penis</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Urinary System</strong></td>
<td><strong>89</strong></td>
<td><strong>7.2%</strong></td>
</tr>
<tr>
<td>Urinary Bladder</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Kidney &amp; Renal Pelvis</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Ureter</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Brain &amp; Other Nervous System</strong></td>
<td><strong>40</strong></td>
<td><strong>3.3%</strong></td>
</tr>
<tr>
<td>Brain</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Other Nervous System</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td><strong>Endocrine System</strong></td>
<td><strong>25</strong></td>
<td><strong>2.0%</strong></td>
</tr>
<tr>
<td>Thyroid gland</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Other Endocrine (including Thymus)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Lymphomas</strong></td>
<td><strong>57</strong></td>
<td><strong>4.6%</strong></td>
</tr>
<tr>
<td>Hodgkin’s lymphoma (nodal)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Non-Hodgkin’s lymphoma (nodal=31, extranodal=21)</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td><strong>Myeloma</strong></td>
<td><strong>8</strong></td>
<td><strong>0.7%</strong></td>
</tr>
<tr>
<td><strong>Leukemia</strong></td>
<td><strong>21</strong></td>
<td><strong>1.7%</strong></td>
</tr>
<tr>
<td>Lymphocytic Leukemia</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Myeloid &amp; Monocytic Leukemia</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td><strong>Mesothelioma</strong></td>
<td><strong>7</strong></td>
<td><strong>0.6%</strong></td>
</tr>
<tr>
<td><strong>Ill-Defined/Unspecified</strong></td>
<td><strong>33</strong></td>
<td><strong>2.7%</strong></td>
</tr>
</tbody>
</table>
Southwest Frequency of Cancer by Gender — 2007

Of the 104 cases diagnosed at Southwest in 2007, 53 were males and 51 were females.

Southwest Major Cancers — Stage at Diagnosis 2007

At Southwest, 89 of 104 melanoma cases (85%) were diagnosed at Stage 0 or Stage 1. When cancer is diagnosed and treated in its earliest stages, the chances for survival are greater.
Summary of Services: Southwest Regional Cancer Center

**Accessible locations**
- Monday through Friday, 8 a.m. to 5 p.m. (Infusion Oncology), 8 a.m. to 4:30 p.m. (Radiation Oncology)
- 24 hour on-call nursing triage
- Emergency services on weekends and holidays, including infusions and radiation oncology services

**Outpatient infusion services**
- Chemotherapy infusions with a wide range of specialized infusions (Cytoxan®, Methylprednisolone, Prolastin®, Remicade®, Tysabri®, etc.)
- Antibiotic, iron/ferrlecit infusions and antibiotics delivered by easily portable CADD pump
- Blood product transfusions and plasma apheresis (plasma removal and transfusion) with the American Red Cross
- PICC line placements and ultrasound-guided PICC line placements
- Central line port access management
- Supportive care for pregnancy-induced nausea and vomiting

**Other specialized procedures**
- Therapeutic phlebotomies
- Cortisol stimulation testing
- Anti-coagulation therapy
- Immune globulin

**Superb, qualified staff**
- **Pre-treatment consult**: An opportunity for the patient and family members to meet with one of Southwest’s nurse navigators, oncology social workers, insurance specialists and pharmacists, all in one visit, usually within one week of meeting with the physician.
- **Oncology-certified nursing staff**: Medical/infusion oncology certified (OCN), advanced cardiac life support (ACLS) certified. Nurse navigators to guide you every step of the way throughout your journey with cancer.
- **Dietitian**: On site staff for dietary needs related to oncology.
- **Pharmacist**: Board-certified, clinical pharmacists on site working closely with staff for oncology education and chemotherapy dosing.
- **Researchers**: Oncology and data management certified. For more information go to www.swmedicalcenter.org/CancerResearch or call 360.514.2155.
- **Oncology social workers**: Provides assessments, support, counseling for patients and their families. Facilitates in connecting people to the appropriate resources, both locally and nation-wide.
Comprehensive Cancer Care at Southwest

Summary of Services

About Southwest Washington Medical Center:

505 NE 87th Ave., Suite 350
PO Box 1600
Vancouver, WA 98668

360.514.2174
www.swmedicalcenter.org/CancerCenter
Order a FREE Cancer Center DVD: www.swmedicalcenter.org/DVD

Summary of Services: Southwest Regional Cancer Center, continued

Superb, qualified staff, continued

- **Insurance specialist:** Helps clarify your rights as an insured patient or Medicare recipient. Provides insurance resources that may be available during treatment.
- **Radiation oncology and CyberKnife® staff:** A collaborative effort across many specialties, including physicians, physicists, therapists, nurses, dosimetrists and other Regional Cancer Center staff. Carefully designed for each patient, treatment includes deciding different energies, directing the precise location and angle of the beam, and discovering ways to modify the dosage.
- **Community education and support groups:** Specialized programs for survivors and their families, including breast, prostate and gynecology cancers. Speakers’ bureau. List of services at www.swmedicalcenter.org/CancerSupport.

Board certified, radiation oncology experts

- **Radiation oncologist:** Consults with patients, establishes and executes treatment, evaluates treatment and follows up.
- **Physicist:** Calibrates radiation oncology equipment and specifications of therapy equipment; performs acceptance testing and QA; measures, analyzes and tabulates beam data; reviews patient charts; provides radiation safety education.
- **Dosimetrist:** Plans treatment and calculates dose, measures radiation, assists physicist with quality control testing and other staff with treatment plans.
- **Radiation therapist:** Responsible for proper simulation and delivery of radiation, use of equipment, implementation of treatment plan, quality assurance and education.

Radiation oncology technology

- CyberKnife® radiosurgery treatment room with precise robotic treatment, cameras and speaker system for image-guided, bloodless surgery treatment
- Clinac 23X with dual-energy photon and electron beams
- Linear accelerators
- Diagnostic PET/CT
- Radiography-based simulation room and CT scanners
- Brachytherapy using CS 137
- Customized patient treatment device fabrication
### Research and clinical trials

Southwest has been a part of many major clinical trials in America and throughout the world, including:

- National Cancer Institute (NCI)
- Columbia River Oncology Program (CROP)
- Southwest Oncology Group (SWOG)
- National Surgical Adjuvant Breast and Bowel Project (NSABP)
- Children’s Oncology Group (COG)
- M.D. Anderson Cancer Center
- University of Rochester
- Clinical Trial Support Unit (CTSU)

#### Breast cancer studies have included:

- Effectiveness of Tamoxifen
- Use of chemotherapy for breast cancer patients
- Fine needle aspiration (FNA) diagnosis of breast cancer
- Pre-op chemotherapy for breast cancer treatment
- Dose-dense chemo for breast cancer therapy
- Sentinel node breast surgery, resulting in less invasive surgery and decreased surgical side effects
- Use of radiation and Tamoxifen in DCIS
- Use of Tamoxifen and Roloxifen in prevention of breast cancer

#### Additional studies have included:

- Genetic testing and gene mapping for various cancers
- Use of genetics to match the most effective treatment for the patient
- Supportive care studies (such as yoga for cancer patients)
- Variety of symptom control studies

### ACOS certification and distinctions

Three-year certification by the American College of Surgeons (ACOS). Only ACOS-certified cancer center in Clark County: 6 commendations for exceeding the accreditation standards in:

- Outcomes analysis and annual reporting
- Documentation around tumor staging
- Patient care guidelines
- Prevention and early detection outreach efforts
- Cancer Registration staff education
- Ongoing program improvement efforts

### Additional certifications and distinctions

- Advanced Cardiac Life Support (ACLS) certified nursing staff
- Only CyberKnife surgery center in the greater Vancouver/Portland metropolitan region

### Additional services available through Southwest

- Interventional pain clinic
- Kyphoplasty and vertebroplasty
- Radio-frequency ablation with interventional radiology
- Robotic surgery with the da Vinci Surgical System®
- Occupational therapy referral
- Physical therapy
- Information and referrals for non-conventional (holistic) therapy, such as massage, herbal treatments, yoga, etc.
- Spiritual care services
Thank you to all of the Cancer Committee members who have generously given their time and talents to ensure that the Regional Cancer Center maintains the pioneering vision of Southwest Washington Medical Center: Exceptional medicine and extraordinary care for every person.

Co-Chairs:

S. Christopher Hoffelt, MD
Co-Chair, Cancer Committee; Medical Director, Radiation Oncology/CyberKnife®, Southwest Washington Medical Center

Donna Feild, RPh, MBA
Co-Chair, Cancer Committee; Administrative Director, Regional Cancer Center and Pharmacy

Medical Staff:

Raman Kansal, MD
Diagnostic Radiology, Columbia Imaging Group

Thomas Dyehouse, MD
Family Wellness Center PC

Dan Hyder, MD
Southwest Pathology Department

Michaelann Liss, DO
Medical Oncology/Hematology, The Vancouver Clinic

Christopher Rubano, MD
Surgery, Pacific Surgical Specialists, ACOS Liaison Physician

Kathy Wang, MD
Pain Management, Southwest Interventional Pain Clinic

Southwest Washington Medical Center Staff:

Paula Allen, RN
Quality Management

Sherril Allen, RN
Manager, Breast Care Center, Breast and Cervical Health Program

Bev Brookshire, CTR
Cancer Registry

Lynn Crawford, RN, BSN
Clinical Manager, 3 North–3 South

Beth Getman, RN, BSN, OCN
Team Manager, Cancer Research

Southwest Washington Medical Center Staff, continued:

Ruthie Gohl, RN, MSN
Director, Medical Services

Rebecca Hambright, RN, OCN, CCRP
Cancer Research

Gail Helland, RN, BS,
Nurse Navigator/Oncology Nurse Coordinator

Kelly Hughey
Registered Dietitian

Sylvia MacWilliams
IRB Program Administrator

Kevin Myles, RN
Clinical Manager, Hospice

Wendy Nava, RN, OCN
Team Manager, 3 North

Chris O’Hara, RN, BSN, OCN
Nurse Navigator/Oncology Nurse Coordinator

Joe Ness, RPh, MHA, VP
Ancillary & Support Services

Jeff Snyder, BS, BA, RTT
Manager, Radiation Oncology/CyberKnife®

Semra Stanley, PharmD, BCOP
Pharmacy

Marie Tesdale, RHIT, CTR
Lead Cancer Registrar

Toniya Villalobos, MSW, LCSW
Social Services

Rochelle White, RN, OCN
RN Team Manager, Infusion Oncology

Additional Committee Members:

Kristin Atkinson
American Cancer Society Representative, Quality of Life Manager

Gerri Trone
Regional Cancer Center, Recorder
The Vancouver Clinic
700 NE 87th Ave.
360.397.3390
- Medical oncology/
  hematology services
- Infusion
  (chemotherapy) program

Southwest Cancer Center
Medical Center
Physicians Building A (north),
Suite 350
360.514.2174
- Medical oncology/
  hematology services
- Infusion
  (chemotherapy) program

Cancer Center
5th St. Building
8821 NE 5th St.
360.514.1900
- Radiation oncology services
- CyberKnife®

Mother Joseph Building
5th St. Entrance,
upstairs (2nd floor)
360.514.2161
- PET and CT services
- Outpatient radiology

Take 87th Avenue
off Mill Plain
for these services.