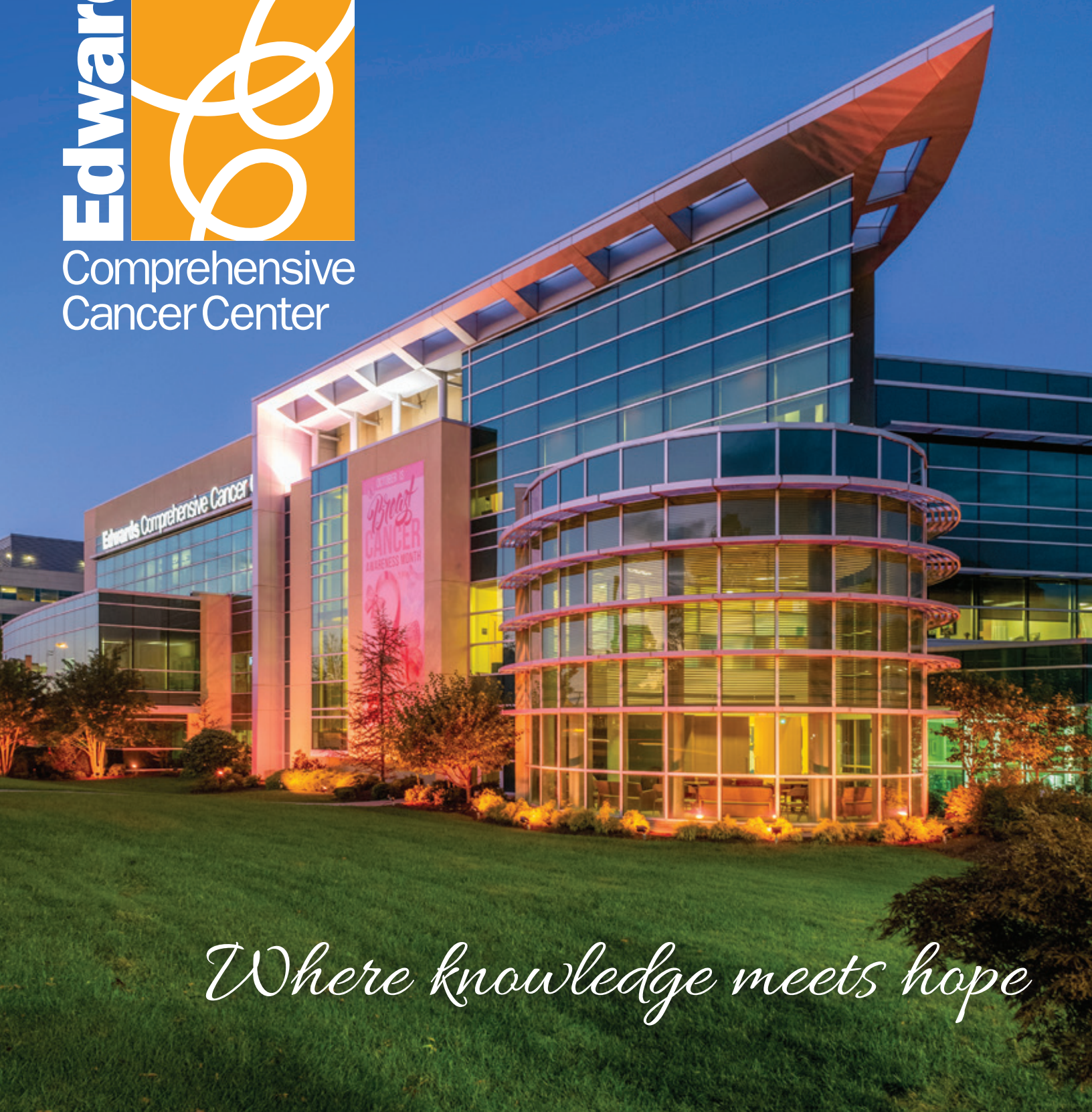


Edwards



2018 **ANNUAL REPORT**

Comprehensive
Cancer Center



Where knowledge meets hope

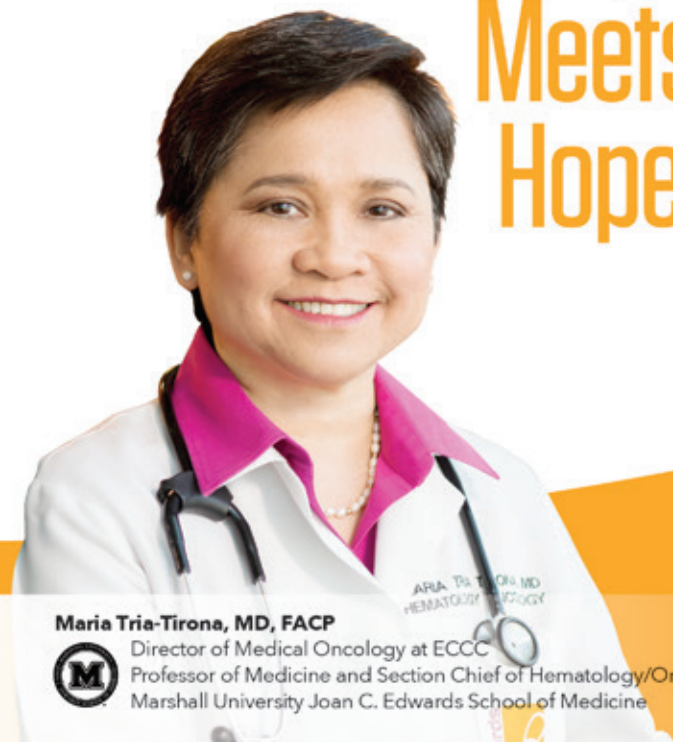


Where Knowledge Meets Hope.

No other facility in the Tri-State has a more complete range of academically affiliated medical, surgical and radiation oncologists providing comprehensive, highly specialized cancer services for both adults and children.

Edwards Comprehensive Cancer Center at Cabell Huntington Hospital – the place where knowledge meets hope.

For more information, call 304.399.6500.



Maria Tria-Tirona, MD, FACP

Director of Medical Oncology at ECCC
Professor of Medicine and Section Chief of Hematology/Oncology
Marshall University Joan C. Edwards School of Medicine



**Edwards
Comprehensive
Cancer Center**

Cabell Huntington Hospital

A Time to Reap and a Time to Sow

A passage from Ecclesiastes best sets the theme for accomplishments at the Edwards Comprehensive Cancer Center (ECCC) in 2018, "To everything there is a season, and a time to every purpose under the heaven ... a time to reap and a time to sow."

In medical oncology we're seeing new drugs virtually each month and we're seeing new treatments developed that have resulted in vast improvements in treating cancers that have been resistant to medical management in the past. For instance, we now have significant treatment opportunities for advanced prostate cancer that we didn't have just a year ago.

We're also seeing advances in radiation oncology including applications of precision radiotherapy such as RapidArc® and CyberKnife®. We're applying them to cancer management that has typically not been used in the past — one example is melanoma where we are seeing good progress. Focal radiotherapy is now being used in kidney, prostate and lung cancers. We are also contemplating using radiotherapy within the tumor through innovations in inserting radioactive implants directly into the tissue, allowing us to gain significant advantages and help patients in ways that would not have been conceivable a year ago.

Surgical oncology is advancing as well, especially in areas of robotics. The Institute for Minimally Invasive Surgery was brought to fruition in 2017 and is the result of great strides in robotic surgery in surgical oncology with specialists in ENT,



neurosurgery and general surgery, as well as urological and gynecological surgery inclusively. With refinement in technology, greater miniaturization of tools, better training and more consistent care processes, we have made huge strides in ways that are benefitting our patients every day.

This year we have reaped what we planted in the past. In the coming decades, we'll reap what we've planted this year. On the horizon is expanding the cancer center from primarily a center of clinical excellence to a center of clinical and research excellence. Dr. Joseph Shapiro, dean of the Marshall

University Joan C. Edwards School of Medicine, Kevin Fowler, Cabell Huntington Hospital's president and CEO, and I see growth through research, conducting clinical trials, testing new drugs and looking at genomics. We envision an institution that meets or exceeds other world-class facilities.

"To everything there is a season and a time for every purpose." This is our time to reap that which has been sown. It is also our time to begin anew in sowing, through new ideas and efforts, the seeds of future growth and innovation. This is our time and our future.

James Jensen, MD

Interim Medical Director,
Edwards Comprehensive Cancer Center

Professor, Dept. of Surgery
Marshall University Joan C. Edwards School of Medicine

ABOUT THE COVER: In honor of Breast Cancer Awareness Month, the ECCC "went pink" throughout October. **Photo by Rick Lee.**

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Dr. Grace Dixon (right), radiation oncologist, prepares a patient for radiation treatment by the *TrueBeam* linear accelerator.


TrueBeam Technology

How a new linear accelerator is *zeroing in* on cancer

The radiation oncology department at the Edwards Comprehensive Cancer Center (ECCC) treats patients with TrueBeam®, a new linear accelerator allowing more treatment options than ever before. One of the options includes stereotactic radiosurgery (SRS). For many patients, SRS is an acceptable, non-invasive alternative to surgery, with a high dose of radiation being administered in one to three fractions. This capability allows treatment not only for a cancer diagnosis, but for some benign processes as well, including intracranial arteriovenous malformations, acoustic neuromas and functional conditions such as trigeminal neuralgia.

There are two major patient benefits to using TrueBeam over other specialized systems. First, TrueBeam is capable of delivering 2,400 monitor units/minute, a dose rate three times greater than other SRS machines, meaning the patient will be on the table for 20 minutes instead of 60 minutes. Shorter

treatment time is not only more comfortable for patients, but also minimizes patient movement, thus improving accuracy. In addition, the ECCC TrueBeam has BrainLab® advanced imaging components that allow real time monitoring of patients while they're receiving treatment — an additional component of quality and safety. Since March of 2016, 34 patients have benefited from the ECCC's ability to provide this highly specialized service. Prior to BrainLab and TrueBeam, patients would have required treatment elsewhere. The board certified radiation oncologists work closely with the neurosurgeons as needed to define what volume needs treatment. Patients may be referred by calling 304.399.6501. ■

 Grace Dixon, MD, is Assistant Professor, Department of Oncology and Marshall University at Joan C. Edwards School of Medicine.



TrueBeam technology allows radiation therapy at specific sites that takes only one-third the time of other stereotactic radiosurgery machines. Shorter treatment times improve accuracy and increase a patient's comfort as well.

PRECISION MEDICINE

Advances in clinical trials *benefit patient treatment* at the ECCC

Listen to any discussion of recent advances in cancer treatment and the term “precision medicine” is likely to arise. Precision medicine finds the best treatment option for individual patients using information about the genetic profile of a tumor to find the treatment most likely to respond. Because treatment is matched to the tumor’s specific genetic mutations, only the mutated cells are killed, resulting in a faster recovery with fewer side effects for the patient. Clinical trials in precision medicine are helping doctors understand how to develop treatments that use the genetic makeup of the tumor to defeat cancer.

Barb Payne, clinical research supervisor at the Edwards Comprehensive Cancer Center (ECCC), said, “A patient 20 years ago would have gotten the latest treatment thought to be the most effective overall. Now we have more and better options. Today specific information can be ascertained about the genetic makeup of the tumor and offer more precise treatment that is tailored to each patient.”

In addition to conducting their own clinical trials, Payne said the oncologists at the ECCC are always looking for opportunities to partner with national clinical trials, giving their patients access to treatments that are truly on the leading-edge of medicine. The ECCC participates in several studies through the National Cancer Institute (NCI) including the NCI-MATCH (Molecular Analysis for Therapy Choice) nationwide trial, which examines if using information about genetic changes in tumors is effective in treating different kinds of cancer; the ALCHEMIST Lung Cancer Trials for patients with early-stage, small-cell lung cancer and the Lung-MAP Master Protocol for patients with advanced squamous-cell lung cancer that has not responded to other treatments. The ECCC also partners with pharmaceutical companies to offer patients even more treatment choices involving precision medicine, including the ASCO trial for women with reoccurring ovarian, peritoneal or fallopian tube cancer.

Payne said because of the availability of medical information online, patients today are highly knowledgeable about



Barb Payne serves as the clinical research supervisor at the ECCC.

their medical options when they choose the ECCC as their treatment facility.

“In the future, it would be ideal to test a patient’s tumor and determine with 100 percent accuracy what therapy will best respond,” said Payne. “We are definitely on that road. Clinical trials will continue to answer questions, and propose new ones, until cancer is eradicated.”

Patients who have questions about clinical trials can call 304.399.6617, or visit www.edwardsccc.org to learn more about how medical advances revolutionizing cancer care are available to patients in the Tri-State. ■

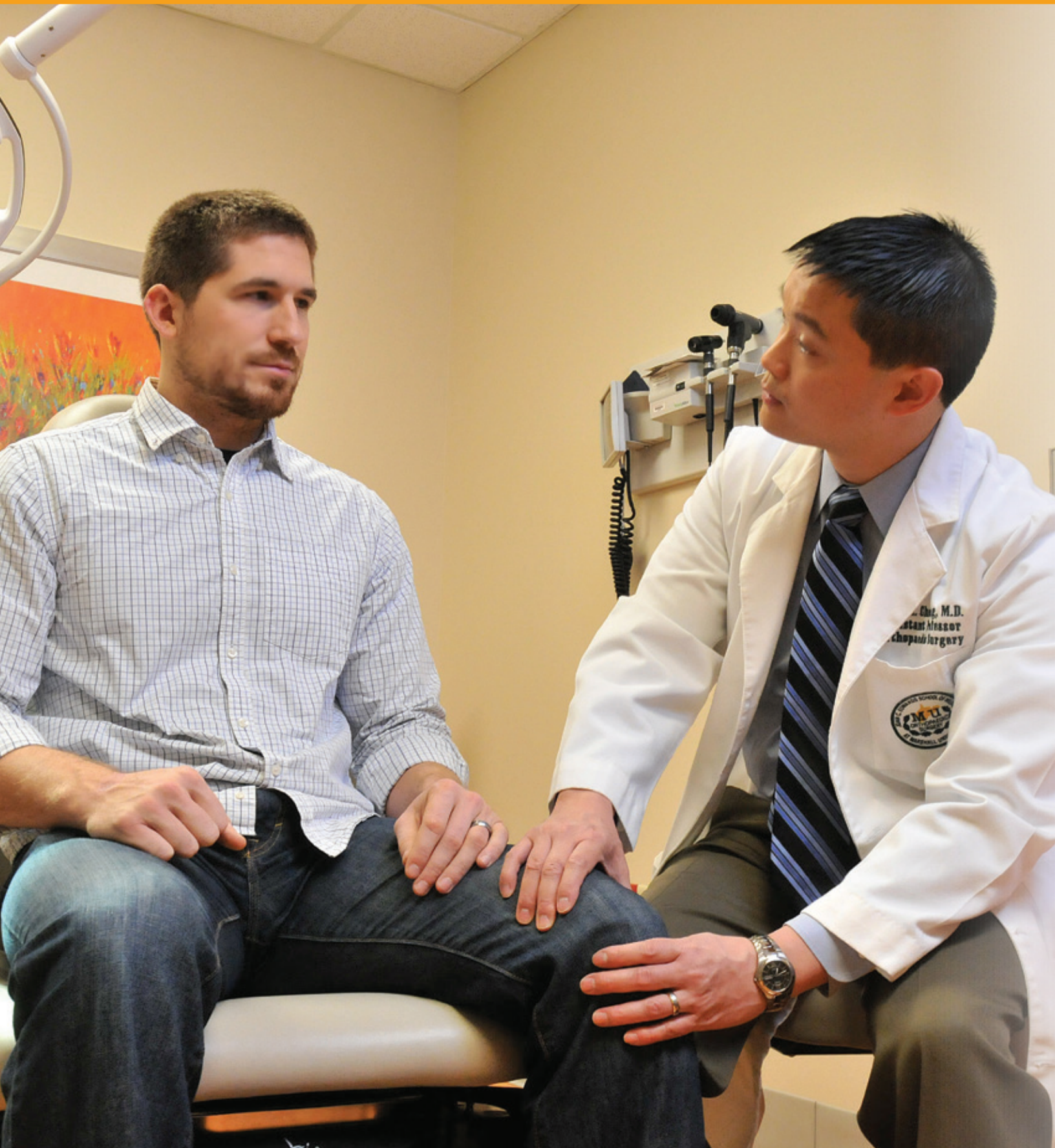


“

BARB PAYNE:

Tumors can now be tested to determine the best treatment tailored to each person's genetic make up.

”



Beating Bone Cancer

The Edwards Comprehensive Cancer Center's (ECCC) department of Orthopedic Oncology treats patients diagnosed with bone cancer or soft tissue sarcoma, as well as patients who have other cancers that have spread to or affect their bones. While this highly-specialized cancer is less common, patients have access to state-of-the-art treatment. Through partnerships with other cancer centers across the nation, patients have access to the latest research protocols and to the most promising medical advances available.

"Studies show that patients prefer not to travel long distances to receive care," said Felix Cheung, MD, associate professor, vice chair of operations and finance. "We are able to provide nationally-recognized care so patients do not need to travel long distances."

Bone cancer is a rare disease, with about 2,500 new cases diagnosed each year, typically in children and people over the age of 60. Soft tissue sarcoma, more prevalent but still relatively rare, is diagnosed in about 15,000 patients each year. There are fewer than 150 orthopedic oncologists in the United States, making the ECCC one of the few facilities to offer this specialized care.

Orthopedic oncology patients at the ECCC benefit from a novel "tumor board," comprised of medical, orthopedic and pediatric oncologists, who meet online to discuss the best treatment for patients. With optimal treatment, many orthopedic cancer patients not only survive, but also return to their normal activities. Dr. Cheung relates the story of a teenager who had primary bone cancer affecting the knee. Part of the shinbone had to be removed and reconstructed, along with chemotherapy and physical therapy. After completing treatment, the teen was able to return to participating in the high school's marching band.


The orthopedic oncology team at the ECCC trains residents and oncology fellows who conduct research and participate in studies such as how CT scans can be used to predict whether a metastatic lesion can cause a fracture or not. They are currently conducting one of the largest studies in the United States



Felix Cheung, MD, orthopedic oncologist.

on the use of artificial bone filler to replace bone that had to be removed as part of cancer treatment. These teaching and research missions allow physicians at the ECCC to use their expertise to help people far beyond the Tri-State region.

"We participate in a substantial number of research projects in the hope that we can further science and help people beyond our community by sharing information and our experience with other doctors, which will help them choose superior options for their patients as well," said Dr. Cheung. ■

 **Felix Cheung, MD**, is Chief of the department of Orthopaedics at the Joan C. Edwards School of Medicine at Marshall University.



Offering *Support*

Supportive Care Medicine is guiding patients through care and treatment

*I*n 2018, the Edwards Comprehensive Cancer Center (ECCC) developed a supportive care model from its former palliative care service line. Changing the name to Supportive Care Medicine better represents the process of care, without alarming patients who may have associated the former term with end-of-life care. Scott Mitchell, MD, board-certified physician specializing in palliative care, coined the new terminology.

Supportive Care Medicine is medical care dedicated to relieving the pain, distress and other symptoms that can accompany serious illness such as cancer. It is specialized care that attempts to improve outcomes by focusing on quality of life issues and taking a “big picture” approach to management.

“Most of the patients we see have more advanced malignancies,” Dr. Mitchell said. “We see a large number of patients who are very appropriate for aggressive treatment and who have the potential for significant improvements in lifespan as well as quality of life.”

According to Dr. Mitchell, a set of criteria is used to indicate whether or not a patient is a good candidate for the supportive care team. More types of cancers and more stages of cancer have been included in the automatic referral system. Additionally, patients can request supportive care medicine — they don’t have to be referred by their doctor. Dedicated nurse navigators are aware of the important issues to consider and

are integral in making sure the patient gets the proper referrals. Through this effective system, each patient gets the supportive care they need as early in their treatment as possible.

Supportive Care Medicine may be provided together with curative and life-prolonging treatment. While most medical treatments are aimed at treating the disease, Supportive Care

Medicine also directs its efforts at minimizing the impact of serious illness on patients and families. Supportive care is about more care — not less. It is medical care that considers the whole person, not just the disease.

The focus of the care is on well-being; on ensuring that all reasonable treatment options are explored; on having patients and families make informed healthcare decisions; on maximizing comfort and minimizing unwanted hospitalizations or treatments and on patients living the best life possible as they navigate through their journey.

“In addition to treating symptoms and teaching patients how to tolerate their chemo or radiation, we ensure that patients have all the pieces of information they need to make informed decisions,” Dr. Mitchell explained. “Ultimately what’s most important is the patient feels informed and understands their options when they start treatment for anything, not just cancer.”

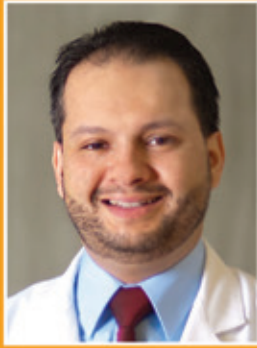
For more information on Supportive Care Medicine offered at the Edwards Comprehensive Cancer Center, visit www.edwardsccc.org or call 304.526.6885. ■



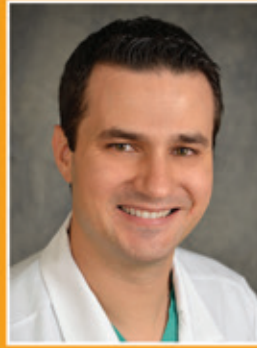
Scott Mitchell, MD, supportive care medicine specialist and Nurse Practitioner Megan Schumaker aim to relieve suffering and improve quality of life for patients.

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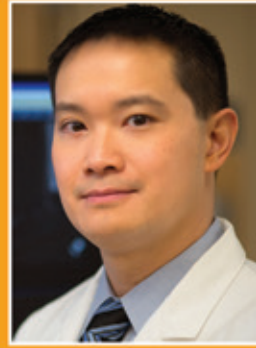
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Mohamed Alsharedi, MD
Medical Oncologist



Nadim Bou Zgheib, MD
Gynecologic Oncologist



Felix Cheung, MD
Orthopedic Oncologist



Grace Dixon, MD
Radiation Oncologist



Paul Finch, MD
*Pediatric Oncologist/
Hematologist*



James C. Jensen, MD
Urologic Oncologist



Yehuda Z. Lebowicz, MD
*Medical Oncologist/
Hematologist*



Mary Legenza, MD
Breast Surgeon



Scott Mitchell, MD
Palliative Care



Charles Murphy, MD
Radiation Oncologist



**Muhammad Omer
Jamil, MD**
*Medical Oncologist/
Hematologist*



Toni Pacioles, MD
*Medical Oncologist/
Hematologist*



Maury Rosenstein, MD
Radiation Oncologist



Linda Stout, MD
*Pediatric Oncologist/
Hematologist*



Maria Tria Tirona, MD
Medical Oncologist



Jack R. Traylor, MD
Breast Surgeon



Rebekah Young, MD
Radiation Oncologist



Navigating Cancer Treatment

Nurse navigators help *guide patients* through the cancer treatment process



Nurse navigators serve as a single point of contact among patients, family and medical workers. They assist cancer patients from diagnosis through a continuum of care, even coordinating appointments and referrals. From left: Melissa Parsons, Melissa Sheppard, Jennifer Brown, Monica Littlejohn, Penny Smith and Missy Massey.

Navigation is a relatively new term in cancer care, but it simply means following a patient from diagnosis through continuum of care. At the Edwards Comprehensive Cancer Center (ECCC) a team of six navigators, all nurses, support patients based on their initial diagnosis. As reflected by the Community Needs Assessment, navigators focus on referrals to non-medical support like transportation, financial issues, dietitian visits and social work services. It also means helping coordinate appointments based on each patient's home situation, as well as helping them cope with the ongoing medical challenges they face. As advocates for their patients, navigators work to resolve obstacles so that patients' appointments, treatments and medical care are seamlessly integrated. Each diagnosis line has a dedicated patient navigator. Sometimes patients have no family nearby, in which case their navigator becomes like family.

Nurse Manager Molly Brumfield leads the navigation team that includes: Melissa Parsons, RN, OCN, gynecologic oncology; Monica Littlejohn, RN, pediatric oncology; Jennifer Brown, RN, OPN-GC, gastro-intestinal, including patients with colon, stomach, esophageal or gallbladder cancer; Penny Smith, RN, OCN, lung cancer; Missy Massey, RN, hematology oncology and Melissa Sheppard, RN, OCN, breast, neck, head and brain cancer.

Nurse navigators work with patients throughout their cancer journey. Their goal is to ease the burden on patients and their loved ones, serve as a single point of contact and help to coordinate the efforts of the medical team as needed. ■

A NURSE NAVIGATOR'S ROLE INCLUDES:

- Discussing and explaining diagnosis and available treatment options
- Coordinating appointments
- Sharing questions or concerns with the care team
- Discussing and explaining medications and their side effects
- Helping patients make informed decisions about treatment and care
- Assisting in coordinating recovery, rehabilitation and aftercare
- Providing support for patients and their loved ones throughout diagnosis and treatment
- Referring patients to appropriate resources for cosmetic or financial concerns

High Standards

ECCC strives to exceed Commission on Cancer Standards through enhancing patient education

The Commission on Cancer (CoC), a program of the American College of Surgeons, recognizes cancer care programs for their commitment to providing comprehensive, high-quality and multidisciplinary patient centered care. The commission is dedicated to improving survival and quality of life for cancer patients through set standards, prevention, research, education and monitoring comprehensive quality care.

To maintain accreditation by the CoC, the Edwards Comprehensive Cancer Center (ECCC) must meet certain

criteria. One of those criteria requires cancer centers to implement two improvements in patient care each year. In 2017, the ECCC conducted a patient satisfaction survey of participants in the Oncology Care Model (OCM). The results of the survey showed opportunities to improve the education process for patients receiving chemotherapy. In addition, the survey revealed the volume of information given to patients in a single visit could be overwhelming.

As such, the OCM Quality Improvement Committee implemented a performance improvement plan that focused on three areas:

1. All patients are to meet with a dedicated nurse navigator who focuses solely on individualized treatment plans.
2. The following five dimensions of care were enhanced:
 - Access
 - Affective communication
 - Exchange of information
 - Enable patient self-management
 - Composite score
3. Provide nurse-led education visit on a separate day, to avoid the overload of information and allow more time for questions and discussion.

“Educating patients on their chemotherapy/immunotherapy treatments is one of the most important things that the navigators do here at ECCC,” said Molly Brumfield, manager of medical and surgical programs. “They try to schedule patient education visits separate from other appointments. This gives patients time to involve as many family members/caregivers as they wish. The education sessions take place in a room separate from the physician’s office area, so it is



Molly Brumfield is the manager of medical and surgical programs at the ECCC.

quiet and free from distractions and allows ample time for learning and questions.”

During the pre-chemotherapy education visits, patients are not only seen by their physician and nurses, but also by a nutritionist and social worker. Leann Ross, OCM quality manager, said beyond the medical ins and outs that come with cancer treatment, the ECCC also provides education on treatments and how treatment may affect their diet. They also discuss legal concerns such as a medical power of attorney.

“We understand that a cancer diagnosis is stressful and we want to help our patients understand everything that is taking place,” Ross said. “Patients often work around jobs and their families, and this helps them plan. Knowledge can take away fear and relieve anxiety.”

Patients receive information from the nurse navigator about:

- Diagnosis/type of disease
- Overall prognosis and intent of therapy (to cure the disease or control it)
- Type of treatment/specific drugs they will receive
- Schedule for treatments and duration
- What to bring on treatment days
- Side effects — both short-term and long-term
- Ways to manage side effects at home
- When to call the physician and how to contact the physician’s office
- What requires an urgent call to the office versus calling 911
- How to monitor lab work and radiology testing
- When to see the physician
- Depression
- Food safety
- Prevention of falls
- Community resources
- Information on clinical trials

Finally, patients are given printed information on these topics along with a DVD they can review at home. The process allows patients to ease into their treatment and feel more comfortable with their care team.

The ECCC is proud to meet CoC’s standards and implement improvements each year that elevate comprehensive, high-quality and multidisciplinary patient centered care that improves survival and quality of life for cancer patients. ■

“

LEANN ROSS:

We understand that a diagnosis of cancer is stressful and we want to help our patients understand everything that is taking place.

”



Leann Ross is the Oncology Care Model Quality manager at the ECCC.

Pride in Quality Care

Edwards Comprehensive Cancer Center

A focus on *accountability* and *quality* improvement



Cancer Registry Manager Phyllis Edwards says the ECCC staff is consistently seeking to exceed benchmarks in patient care.

Providing consistent top-quality care is a point of pride for the Edwards Comprehensive Cancer Center (ECCC) team. So are the results of a recent survey by the American College of Surgeons Commission on Cancer that is designed to measure the effectiveness of the ECCC's accountability and quality improvement measures.

"We were well over the standards on most of the results," Phyllis Edwards, cancer registry manager, said. "As a participant in the Commission on Cancer, we develop action plans for any areas



where we can improve. I'm proud to work for a hospital that puts a lot of work into caring for our patients and making sure they receive the best treatment in a timely manner."

ECCC staff is consistently seeking to exceed benchmarks in patient care by providing data to support the high quality initiatives. Staff welcome the opportunity to rethink how to do things to improve care for patients.

For more information about quality care at the Edwards Comprehensive Cancer Center, visit www.edwardsccc.org or call 304.399.6500. ■

STANDARD 4.4 ACCOUNTABILITY MEASURES AND STANDARD 4.5 QUALITY IMPROVEMENT MEASURES 2018 CP³R PERFORMANCE MEASURES CANCER REGISTRY DATA

CabellHuntington Hospital/Edwards Comprehensive Cancer Center Accountability and Quality Improvement Performance Rates (CP³R)

Primary Site	Measure Specifications	COC Standard (Benchmark)	Estimated Performance Rate (EPR)
			2017
Breast	BCSRT – (Accountability) Radiation is administered within 1 year (365 days) of diagnosis for women under the age of 70 receiving breast conservation surgery for breast cancer	90%	98%
	HT – (Accountability) Tamoxifen or third generation aromatase inhibitor is considered or administered with 1 year (365 days) of diagnosis for women with AJCC T1c or Stage II or Stage III hormone receptor positive breast cancer	90%	100%
	nBx – (Quality Improvement) Image or palpation-guided needle biopsy to the primary site is performed to establish diagnosis of breast cancer	80%	94%
	MAC – (Accountability) Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c or Stage II or III hormonal receptor negative breast cancer	n/a	88%
	MASTRT – (Accountability) Radiation therapy is considered or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with greater than or equal to four positive regional lymph nodes	90%	100%
Colon	ACT – (Accountability) Adjuvant chemotherapy is considered or administered with 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC stage III (lymph node positive) colon cancer	n/a	88%
	12RLN (Quality Improvement): At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.	85%	95%
Lung	LCT (Quality Improvement): Systemic chemotherapy is administered within 4 months to day preoperatively or day of surgery to 6 months postoperatively, or it is recommended for surgically resected cases with pathologic lymph node positive (pN1) and (pN2) NSCLC.	85%	100%
	LNoSurg (Quality Improvement): Surgery is not the first course of treatment for cN2, M0 lung cases	85%	100%
Gastric	G15RLN : (Quality Improvement) At least 15 regional lymph nodes are removed and pathologically examined for resected gastric cancer	80%	0
Rectum	RECRCT (Quality Improvement): Preoperative chemo and radiation are administered for clinical AJCC T3N0, T4N0 or Stage III; or postoperative chemo and radiation are administered within 180 days of diagnosis for clinical AJCC T1-2N0 with pathologic AJCC T3N0, T4N0, or Stage III; or treatment is recommended; for patients under the age of 80 receiving resection for rectal cancer.	85%	100%

References: American College of Surgeons/Commission on Cancer CP³R

Screening Guidelines for Breast Cancer

*I*n the past few years, there has been considerable controversy about screening guidelines for breast cancer. This has raised questions of what age to begin mammogram screening and how often, as well as when to stop screening.

There is a lot of data showing that early detection of breast cancer can result in earlier stage at diagnosis. Survival is usually excellent if breast cancer is found at an early stage. A mammogram is the only imaging modality reasonable for screening. Other modalities such as MRI and ultrasound are time consuming, more costly and have higher false positive rates. Results from randomized clinical trials and other studies show that screening mammography can help reduce the number of deaths from breast cancer among women ages 40 to 74, especially for those over age 50. However, there are significant false positive rates for mammograms. This means, that the mammogram shows a lesion that may require a biopsy or close observation and the lesion is not cancerous or even precancerous. This can result in significant anxiety as well as increased cost.

The randomized studies mentioned above were done at a time when digital and 3D mammograms were not widely available. Both of these modalities have been shown to improve early detection and decrease false positives.


The American College of Radiology adheres to the guidelines of a yearly mammogram starting at age 40 for women with an average risk of breast cancer. That means there is not a strong family history of breast cancer or ovarian cancer or previous radiation to the chest.

The risk of breast cancer increases with age so decreasing screening after age 55 is not recommended. The Edwards Comprehensive Cancer Center recommends women stop screening if they have multiple medical problems that may end their lives within the next five years. Age cutoff is extremely difficult, since there are some very healthy 80-year-old women who may live another 10 to 15 years.

Some women have a very strong family history of breast or ovarian cancer, and may need to start screening much earlier. They should consider mammograms about 10 years prior to their youngest relative. If their mother was 40 when she was diagnosed, the woman should start screening at 30. Also, this person should be evaluated by a genetics counselor, as well as a breast surgeon. She may also benefit from MRIs at regular intervals, since this is much better at detecting cancer in younger women with normally very fibrous, dense breasts.

A screening mammogram is only indicated if a woman has no complaints that could be indicative of breast cancer. She has no palpable mass, no skin changes and no nipple discharge. Cyclic breast pain is not included in this exclusion list. If a person feels a lump (patient or care provider), they should have a diagnostic mammogram and ultrasound. The main difference in the technique is that a radiologist will review the films while the patient is in the imaging center and recommend further testing while she is still there. This avoids calling the patient back for additional imaging as well as alerting the radiologist that there may be a problem in a specific area of the breast.

To learn more about screening for breast cancer, call the Edwards Comprehensive Cancer Center at 304.399.6556. ■

 **Mary Legenza, MD**, Breast Surgeon, is an assistant professor, in the Department of Surgery at the Marshall University Joan C. Edwards School of Medicine.

(Opposite) Dr. Mary Legenza specializes in breast oncology.



Mary Legenza, M.D.
Breast Oncology



Pediatric OB/GYN *Stresses* HPV *Vaccination* for Youth

Immunizations are an important part of a child's health. In 2006, the Center for Disease Control (CDC) recommended a new immunization for children ages 11 to 12, to combat more than 40 types of the human papillomavirus (HPV) and certain types of cancer.

"The human papilloma virus is the most common sexually transmitted infection in the United States," said Jennie Yoost, MD, pediatric obstetrician and gynecologist at Hoops Family Children's Hospital. "It is recommended that both boys and girls be vaccinated at an early age in order to combat this infection that is linked to cancer."

According to the CDC, HPV is very common, infecting approximately 14 million people each year. More than 79 million Americans are currently infected. The infection shows little to no symptoms or health problems and most strains go away on their own. But sometimes, the infection can persist and lead to various types of cancer and other health problems.

"Most people do not have symptoms and do not know they are infected and/or spreading HPV. It is important to immunize at a young age because most children are not sexually active yet and the vaccine has the greatest effect prior to exposure to HPV, which is transmitted through sexual activity," Yoost explained.

Yoost said getting the immunization is a protectant against several types of cancer that have been linked to HPV including cervical, vaginal, vulvar and oropharyngeal cancer (cancer in the back of the throat, tongue and tonsils).

According to the CDC, clinical trials have shown that getting vaccinated at age 11 or 12 offers close to a 100% protection against pre-cancers and genital warts.

"The advancements in the types of immunizations




Dr. Jennie Yoost (second from left) discusses the advantages of the HPV vaccine with the mother of a young patient.

recommended to prevent HPV have increased. One brand of HPV immunization drug, Gardasil, now offers protection against nine types of HPV, where it once only covered four," said Yoost. "Getting the vaccine at an early age produces a higher immune response in preteens than it does in older teens and young women."

The HPV vaccine is administered three times over a six month period. Yoost said the vaccine can be given to young women through age 26, and young men through age 21.

"Even if someone is sexually active, they should still get the HPV vaccine to help protect against the various strains, while they're still young," she said. ■

 **Jennie Yoost, MD**, pediatric and adolescent gynecologist, is an associate professor in the Department of Obstetrics & Gynecology at the Marshall University Joan C. Edwards School of Medicine.

Celebrations & EVENTS



SURVIVORS' DAY

Each year, the Edwards Comprehensive Cancer Center holds a celebration of life with survivors and their families. Food, entertainment, games and prizes are all part of the celebration offered free of charge on the hospital grounds.



LIGHT IT UP

Kevin Fowler, president and CEO of Cabell Huntington Hospital, joins cancer survivor Paula Paisley to flip the switch. The ECCC kicked off Breast Cancer Awareness Month by lighting the Cancer Center pink.



CONCERT FOR A CURE

The Cabell Huntington Hospital and the St. Mary's Medical Centers' Foundations held the inaugural Concert for a Cure featuring Creedence Revived and Dear John. The event was held at the Barbourville Park Amphitheater in August.



BREAST CANCER AWARENESS DINNER

Breast cancer survivors who received care at the Cabell Huntington Hospital Edwards Comprehensive Cancer Center were invited to a celebration dinner hosted by the center at the New Baptist Church in Huntington. Survivors and their families were treated to dinner, entertainment and raffles during the annual event dedicated to celebrating life.



Innovative

Cabell Huntington Hospital Named Center of Excellence for Minimally Invasive Gynecologic Surgery

Today's most advanced robotic technology can be found at Cabell Huntington Hospital. In the hands of our exceptional robotic surgeons, that technology allows minimally invasive procedures to be performed that break the boundaries of human performance. For our patients, that means better outcomes with less pain and faster recovery. It's why small incisions are the best decision.

Nadim Bou Zgheib, MD, FACOG
Gynecologic Oncology Surgeon
Surgeon of Excellence in Minimally Invasive Gynecology by COEMIG

Dr. Bou Zgheib is a board-certified and fellowship-trained gynecologic oncologist who has completed extensive training in gynecologic cancer diagnosis and treatment and minimally invasive surgery, including the *da Vinci® Surgical System*.



Assistant professor, Department of Obstetrics & Gynecology
Marshall University Joan C. Edwards School of Medicine



THE INSTITUTE FOR
Minimally Invasive
 **Surgery** *at Cabell
Huntington Hospital*

In association with Marshall Obstetrics & Gynecology and the Edwards Comprehensive Cancer Center

