

# Oncology Services







**COMPREHENSIVE CANCER CARE TREATING THE WHOLE PERSON - BODY, MIND AND SPIRIT.**



## Chairman's Report

In 2013, Texas Health Presbyterian Hospital Dallas broke ground on a new comprehensive cancer center, completed in December of 2014.

This advanced facility will be the "bricks and mortar" manifestation of our unified approach to cancer services. The center will house clinicians, nurse navigators, genetic counseling services through our Cancer Risk and Assessment program, imaging services, spiritual support services and community support services. The comprehensive nature of this facility mirrors our approach to cancer care and calls to mind our commitment to care for the whole patient - mind, body and spirit.

Texas Health Dallas is committed to providing the highest quality cancer care. This commitment is demonstrated by the fact that the oncology program is a four-time recipient

continuum is demonstrated by our strong partnership with Cancer Support Community, who provides comprehensive cancer support at no charge to their members. Our cancer support groups are among the largest and most active in the Dallas-Fort Worth area. Dedicated involvement by our care providers makes the difference.

Quality improvement studies are conducted each year to identify opportunities for improvement in services. Two studies performed this year were "Treatment of Non-Small Cell Lung Cancer" by Dr. Melvin Platt and "Breast Cancer Recurrence of Patients Treated with Breast Conserving Surgery" by Dr. Carolyn Thomas.



of the American College of Surgeons Commission on Cancer Outstanding Achievement Award, the highest level of approval from the Commission on Cancer, and is accredited by the National Accreditation Program for Breast Centers. Additionally in 2014, Texas Health Dallas was accredited by the CEO Gold Standard, a workplace-based wellness accreditation program, which recognizes organizations that demonstrate a commitment to lower their risk of cancer, detect it early, and ensure access to high-quality care for their employees.

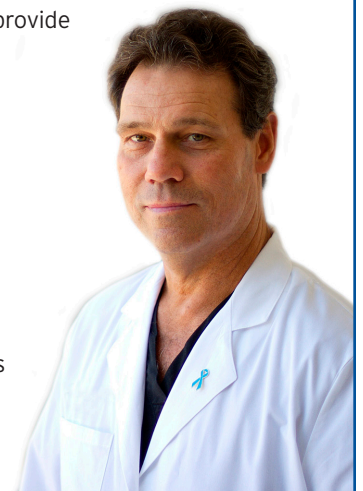
Providers of oncology services at Texas Health Dallas continue to reach out to the community in the form of risk assessments and screenings, when indicated, as well as supporting fundraisers for oncology focused organizations. Our dedication to caring for oncology patients and their families throughout their care

The Texas Health Dallas comprehensive cancer program continues to evolve to meet the needs of the cancer patients in the community we serve. We look forward to the opening of the new cancer center with great anticipation, knowing that it will enhance the individualized and patient-centered oncology care we provide here at Texas Health Dallas.

**Pat Fulgham, M.D.**

Director of Surgical  
Oncology Services

Chairman, Oncology Process  
Improvement Committee



# Treatment of Stage and 2 Lung Cancer at Texas Health Presbyterian Hospital Dallas in 2012 and 2013 Including Early Experience with Robot-Assisted Lobectomy

By Melvin Platt, M.D.

This study was done to evaluate adherence to published national guidelines for the management of lung cancer.<sup>1</sup> We also examined our initial experience with robot-assisted lobectomy. Two da Vinci robots are available in our institution and are used primarily in urology and gynecology but may well have a place in the management of lung cancer.

A total of 33 cases were reviewed over a two year time period, 2012 and 2013. The cases included Stage 1 and 2 non-small cell lung cancer cases which were eligible for lung resection. The surgery was performed by three surgeons in our institution. Included in this analysis were the first six robot-assisted lobectomies. A 34th case was excluded from the study because of an early death on postoperative day one due to cardiac arrest. This resulted in a 3% mortality rate for this series of patients.

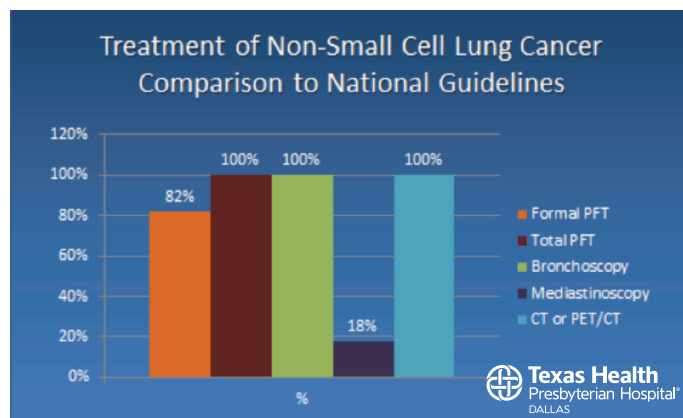
One guideline evaluated was pulmonary function testing (PFT). PFT was documented in 27 of 33 cases (82%). In the remaining six cases there was either a description of normal pulmonary function testing by the referring pulmonologist or the patient was tested by walking up at least one flight of stairs with the surgeon accompanying the patient with oximetry monitoring.

Bronchoscopy was another guideline evaluated. Bronchoscopy was performed 100% of the time. It was performed either by the referring pulmonologist prior to surgery or was performed in the operating room at the time of the lung resection, which is acceptable in the guideline. All patients had either a standard CT scan or a PET/CT scan prior to surgery.

One guideline that was underutilized was mediastinoscopy, which is a category 2B guideline, meaning that there is no consensus that it is appropriate. In this group of patients it was only performed if the tumor was more centrally located or if there was borderline lymph node enlargement on standard CT or if there was questionable uptake of radioactivity on a PET scan. As such, mediastinoscopy was only performed in 6 of 33 patients (18%). Almost all of them were stage 2.

With regards to our early experience with robot-assisted lobectomy, the cases selected for this procedure were biased toward peripheral tumors with generally good pulmonary function. There were no conversions to an open procedure. The average age was similar in the robotic and open cases, 68.5 years in the robotic and 72.8 years in the open. Major reasons for exclusion from the robot-assisted surgery included one patient with a previous thoracotomy, another who required chest wall resection, and one who had a lung resection combined with off-pump coronary artery bypass surgery. The major exclusion was due to marginal pulmonary function. Patients with marginal pulmonary function may actually benefit the most from the less-invasive procedure.

Length of stay was slightly better in the robotic group at 5.33 days compared to 6.03 days for the open procedure. However, one open case with a prolonged air leak and subsequent empyema requiring drainage a stay of 34 days. If that case is excluding then the length of stay for open cases was 5.91 days, not much different from the robotic cases. In fact, there were two of the robotic cases that went home in 3 days, and only one of the open cases did so. Overall these initial results with robot-assisted lobectomy are encouraging and should improve with more experience.



## References

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# Recurrence Rates after Breast Conserving Surgery for Breast Cancer at Texas Health Presbyterian Hospital Dallas

By Carolyn Thomas, M.D.

This study was done to evaluate the recurrence rates after breast conserving surgery (i.e. lumpectomy) for breast cancer and compare this to other published recurrence rates in the literature. Recurrence rates were broken down into local recurrences, regional recurrences, and distant recurrences. All epithelial histologies of breast cancer were included, as was ductal carcinoma in situ.

Numerous modern prospective randomized controlled trials demonstrate that breast conserving therapy offers survival rates equivalent to mastectomy.<sup>1-7</sup> Breast conserving therapy includes lumpectomy with radiation therapy. Local recurrence rates are minimized with negative surgical margins, administration of adjuvant radiation, and systemic therapy (endocrine and chemotherapy) as indicated for individual patients. When radiation is administered after surgery, local recurrence rates are 4.4% - 13%. When radiation is omitted after surgery, local recurrence rates are 13.3% - 35.2%.<sup>1,2,8</sup> Distant recurrence rates vary by tumor stage and biology.

The years 2006 to 2012 were chosen to capture the patients with the longest follow-up that were still being followed by the Tumor Registry. Consecutive cases were performed on this campus by several surgeons, and 786 charts were reviewed. Sixteen charts were excluded for the following reasons: patient went on to have mastectomy (either changed mind about breast conservation or found out they carried genetic mutation), erroneous entry in the Registry as lumpectomy, duplicate entries in the Registry. None of the patients excluded for going on to have mastectomy did so because of loco-regional recurrence in the index breast. A total of 770 charts were eligible for inclusion in the reviewed data. All data collected was verified in the electronic medical record by either Dr. Thomas or the Tumor Registry staff. Negative surgical margin was defined as "no ink on tumor".

Of 770 reviewed charts, there were 36 recurrences (recurrence rate 4.67%, includes local, regional and distant recurrences). There were 7 local recurrences (rate 0.90%). There was 1 regional recurrence (rate 1.29%). There were 18 distant recurrences (rate 2.33%). Sites of distant recurrence included: bone (4), brain/CNS (6), liver (2), adrenal (1), lung (4), pleura (2). Upon detailed review of the 7 cases where a local recurrence did occur, all patients had negative surgical margins except for one who had a microscopically

positive margin for DCIS. Unfortunately, she declined radiation therapy and discontinued endocrine therapy due to side effects. Of the 18 patients who had distant recurrences, all but 2 had negative surgical margins. One of the two declined further surgery to clear margins and the other had a focally positive posterior margin for DCIS where there was no further tissue to excise.

Adjuvant radiation therapy was administered to 614 (79.7%) patients. Chemotherapy (neo-adjuvant or adjuvant) was administered to 476 (61.8%) patients. Of the 296 patient not receiving chemotherapy, 26 patients refused therapy and 28 patients were not offered chemotherapy due to comorbidities. Of those patients with hormone receptor positive cancers, 424 (55.0%) patients received endocrine therapy. There were 20 patients for whom endocrine therapy was recommended but the patient declined, and 15 patients for whom endocrine therapy was indicated but not offered due to comorbidities. Endocrine therapy was considered in all cases of hormone positive breast cancers unless the patient failed to present for post-operative follow-up.

In conclusion, the local recurrence rate after breast conserving surgery at Texas Health Presbyterian Dallas is far below reported international values. There is deliberate attention to the various controllable factors that influence the risk for local recurrence by our multidisciplinary breast care team here at Texas Health Presbyterian Dallas which improves patient outcomes.

## References

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