As health care providers, it is our job to ensure that our patients are aware of and have access to the best care options available to them regardless of race or ethnicity; however, current studies have shown what we already know; this is not always the case.

Recent analyses of clinical trials found that there is an extreme lack of diversity in patient participation.1 Findings showed that only 4-6% of participants are black and 3-6% are Hispanic, despite the fact that these two groups make up 15% and 13%, respectively, of patients with cancer.1 In response to these analyses and several others demonstrating the racial disparities in clinical trial participants, the American Society of Clinical Oncology (ASCO) and the Association of Community Cancer Centers (ACCC) recently announced a joint initiative to increase participation from underrepresented groups. Along with the announcement came a request to the community for ideas on ways to overcome known barriers, such as provider bias, insurance coverage/cost of care, literacy-related issues and lack of awareness among other factors.

Yet, clinical trials are not the only facet of cancer care and treatment that has seen racial disparities. There are also racial disparities when evaluating socio-economic status. A recently published study in *JNCI Cancer Spectrum*, compared person-years of life lost (PYLL) and lost earnings due to premature cancer deaths by race/ethnicity and found that $3.2 billion of lost wages could have been avoided if age-specific PYLL and lost earning rates were equal for non-Hispanic whites and non-Hispanic blacks.2 This study evaluated PYLL and lost wages among patients 16-84 years of age belonging to the following racial groups: non-Hispanic white, non-Hispanic black, non-Hispanic Asian or Pacific Islander and Hispanic.

Additionally, a large review conducted by Coughlin examining social determinants to breast cancer risk suggested that “poverty, lack of education, neighborhood disadvantage, residential segregation by race, racial discrimination, lack of social support and social isolation play an important role in stage at diagnosis.”3 The association of being exposed to racism and subsequent engagement in cancer-linked behaviors was noted as it relates to tobacco use, unhealthy alcohol use and elevated BMI.

Innovative Lung Nodule Clinic Opens at Cherokee Campus

Positive Impact of Radiation Therapy Patient Education Materials and Survivorship Care Plans for Transition to Surveillance

Clinical Trials and Research

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**Additional Reading**


### Featured Breast Cancer Clinical Research Trials Available at NHCI

**Trial Number and Name**

**NCT Identifier**

**Key Eligibility Criteria**

- Must have metastatic breast cancer.
- Must be initiating trastuzumab-based HER2-targeted therapy in 1st or 2nd line setting.
- Stable CNS disease allowed.
- Patients must be at an increased risk for cardiotoxicity with previous anthracycline exposure and/or at least one risk factor for heart disease: (-) LVEF 50-54% by local ECHO read.
- Age ≥ 65.
- BMI ≥ 30 kg/m².
- Current/prior anti-hypertensive therapy.
- Diagnosis of coronary artery disease.
- Diagnosis of diabetes mellitus.
- Diagnosis of atrial fibrillation/flutter.

**Study Design**

Patients not on a current beta blocker, ARB or ACE inhibitor will be randomized 1:1 to the following:

- Arm 1: Carvedilol
- Arm 2: No prophylaxis

Patients on a current beta blocker, ARB or ACE inhibitor will be randomized 1:1 to the following:

- Arm 1: Carvedilol
- Arm 2: No prophylaxis

All patients will be assessed for cardiac function by Central ECHO Lab.

(by: Karen Buhariwalla, DO)

As health care providers, it is our job to ensure that our patients are aware of and have access to the best care options available to them regardless of race or ethnicity; however, current studies have shown what we already know; this is not always the case.

Recent analyses of clinical trials found that there is an extreme lack of diversity in patient participation.1 Findings showed that only 4-6% of participants are black and 3-6% are Hispanic, despite the fact that these two groups make up 15% and 13%, respectively, of patients with cancer.1 In response to these analyses and several others demonstrating the racial disparities in clinical trial participants, the American Society of Clinical Oncology (ASCO) and the Association of Community Cancer Centers (ACCC) recently announced a joint initiative to increase participation from underrepresented groups. Along with the announcement came a request to the community for ideas on ways to overcome known barriers, such as provider bias, insurance coverage/cost of care, literacy-related issues and lack of awareness among other factors.

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Similar to the previous analyses and ASCO-ACCC collaboration, these studies also concluded that the only way to achieve equal access and reduce the undue socio-economic burden is to remove or reduce the longstanding barriers associated with racial disparities. To do this, we as a community health care facility must come together and work towards achieving this goal.

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(continued on page 2)
### Clinical Research Trials Available at NHCI for Breast Cancer

(continued from page 1)

<table>
<thead>
<tr>
<th>Trial Number and Name</th>
<th>NCT Identifier</th>
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</table>

**Key Eligibility Criteria**
- Must have HR+, HER2-negative metastatic breast cancer.
- Must be refractory to or relapsed after at least two (but not more than four) prior chemotherapy regimens.
- Must have received at least one taxane, one prior hormonal therapy and two CDK 4/6 inhibitor in any setting.

**Study Design**
Patients are randomized 1:1 to the following:
- Arm 1: Sacituzumab govitecan
- Arm 2: Physician’s Choice (eribulin, capecitabine, gemcitabine, vinorelbine)

| NCT-375: A Randomized, Double-Blind, Phase III Trial of Paclitaxel /Trastuzumab/ Pertuzumab With Atezolizumab or Placebo in First-Line HER2-Positive Metastatic Breast Cancer | NCT03199885 |

**Key Eligibility Criteria**
- Must have locally recurrent, unresectable or metastatic HER2+ breast cancer.
- Cannot have received therapy for metastatic disease.
- ECOG PS 0-1.

**Study Design**
Patients will be randomized 1:1 to the following:
- Arm 1: Paclitaxel + Trastuzumab + Pertuzumab + Placebo
- Arm 2: Paclitaxel + Trastuzumab + Pertuzumab + Atezolizumab

| C-381: Randomized, Double-blind, Phase III Study of Tucatinib or Placebo in Combination With Ado-trastuzumab Emtansine (T-DM1) for Patients With Unresectable Locally-advanced or Metastatic HER2+ Breast Cancer (HER2CLIMB-02) | NCT03975647 |

**Key Eligibility Criteria**
- Must have locally recurrent, unresectable or metastatic HER2+ breast cancer.
- Must have had prior treatment with a taxane therapy and trastuzumab in any setting (separately or in combination).
- Must have progressed on last therapy.

**Study Design**
Patients will be randomized 1:1 to the following:
- Arm 1: Placebo + T-DM1
- Arm 2: Tucatinib + T-DM1

| NSH1221: A Phase II Multi-Institutional Study of Concurrent Radiotherapy, Palbociclib, and Hormone Therapy for Treatment of Bone Metastasis in Breast Cancer Patients | NCT03691493 |

**Key Eligibility Criteria**
- Must have metastatic ER/PR+, HER2-negative breast cancer with confirmed bone metastases.
- Must be receiving palbociclib plus hormone therapy.
- ECOG PS 0-2.
- Stable CNS disease allowed.

**Study Design**
All patients will undergo radiation therapy over 5-10 days while receiving palbociclib and hormone therapy.

| NSH1222: A randomiZed phAse II trial of fulvestraNt wiTh or Without Ribociclib After Progression on Anti-estrogeN Therapy Plus Cyclin-dependent Kinase 4/6 Inhibition in Patients With Unresectable or Metastatic Hormone Receptor Positive, HER2 Negative Breast Cancer (MAINTAIN Trial) | NCT02632045 |

**Key Eligibility Criteria**
- Must have HR+, HER2-negative adenocarcinoma of the breast with metastatic or unresectable disease.
- Must be postmenopausal or receiving ovarian suppression.
- Stable CNS disease allowed.
- ECOG PS 0-1.
- Must have progressed after treatment with an AI, tamoxifen or fulvestrant, plus palbociclib as standard of care OR received a CDK4/6 inhibitor.

**Study Design**
Patients are randomized 1:1 to the following:
- Experimental Arm: Fulvestrant (or exemestane) + ribociclib
- Control Arm: Fulvestrant (or exemestane) + placebo

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### IN THE NEWS: Updates for Clinicians

**Analysis Shows Improved Outcomes with a Commonly Used Salvage Regimen When Used as Initial Induction Therapy in Patients with Non–favorable-risk Acute Myelogenous Leukemia**

*By: Melhem M. Solh, MD*

Induction of acute myeloid leukemia (AML) has not witnessed any major changes for the last few decades. A 7+3 regimen, which is seven days of cytarabine and three days of an anthracycline (typically daunorubicin), remains the most used induction regimen for AML patients. We conducted a retrospective analysis to determine if a commonly used AML salvage regimen, FLAG±Ida (fludarabine, high-dose cytarabine and G-CSF with or without idarubicin), would improve outcomes when used as remission induction compared to 7+3.1

A total of 304 consecutive patients with non–favorable-risk AML that received initial treatment with either 7+3 (86 patients) or FLAG±Ida (218 patients) at Northside Hospital (NH) were included. Patients in the FLAG±Ida group were significantly more likely to achieve remission after one course of induction (74% vs. 62%, *P*<0.001) and had a significantly faster time to achieve complete response compared to 7+3 (30 vs. 37.5 days, *P*<0.001). The three-year post-remission overall and disease-free survival rates were

(continued on page 3)
also significantly better for patients receiving FLAG±Ida vs. 7+3 (OS 54% vs. 39%, \( P=0.007 \), see figure). Factors associated with post-remission survival included age at first complete response, NCCN risk group, induction regimen and whether patients underwent transplant. Our data reveal a new remission induction regimen option in the armamentarium of AML therapies that yields better survival outcomes than the commonly used 7+3.


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**Elevating The Patient Experience at NHCI**

**NHCI Studies Demonstrate Positive Impact of Radiation Therapy Patient Education Materials and Survivorship Care Plans for Transition to Surveillance**

*By: Brooke Balun, MSN, APRN-BC, AOCNP*

Patient education is an important aspect of health care and a cornerstone in radiation oncology nursing practice. Oncology patients may have preconceived notions about the effectiveness and safety of radiation therapy. Technology quickly changes in the radiation therapy field, and it is essential that education materials stay current. We recently updated our radiation oncology patient education materials, and then assessed how the improvements impacted patient perception. Results were showcased virtually at the Annual Congress of the Oncology Nursing Society (ONS) in September. Key findings of the study are shown in Figure 1.

**Figure 1. Patient Perception of New Radiation Therapy Patient Guide**

- Patient education materials should be user-friendly to the patient and evidence-based. Materials should be assessed periodically for up-to-date content and relevance.
- Implementation of new patient education materials in a large center with multiple satellite offices must include staff education on utilization and content; patient education must be tailored and personalized to the individual client.
- Personalized patient education improves the patient's experience and as demonstrated in this study, new education materials can positively impact patient satisfaction.

Patient education, as stated previously, is critical in radiation oncology, but equally important is survivorship education. Though essential to survivorship care, the impact and delivery of a survivorship care plan to transition patients from treatment to surveillance remains elusive. We therefore studied the impact of survivorship education provided by a radiation oncology nurse to women diagnosed with early-stage breast cancer who completed radiation therapy. Findings of our pilot study were also featured at the virtual Annual ONS 2020 Congress. At patients’ four to six-week follow-up visit, nurse practitioners, registered nurses and licensed practical nurses provided patients with their survivorship care plan and discussed late and long-term side effects of radiation therapy. Results of the patient satisfaction survey administered are shown in Figure 2.

**Figure 2. Patient Satisfaction Post Survivorship Visit**

Overall, our pilot study demonstrated improvements in patient self-confidence, delivery of the survivorship care plan, transition of care from active treatment to surveillance and overall understanding and satisfaction with the information shared. The data show that our patients benefit from the information shared at this visit and our nursing staff provides an effective delivery of personalized survivorship care plans.
Clinical Trials and Research

Success of the Tomosynthesis Mammographic Imaging Screening Trial (TMIST)

By: Katie Moore

In May 2018, Northside Hospital (NH) opened the international breast screening study, Tomosynthesis Mammographic Imaging Screening Trial (TMIST). TMIST is a randomized breast screening trial that will help researchers learn about the best ways to find breast cancer in women who have no symptoms. It compares two types of FDA-approved digital mammography: standard digital mammography (2D) and a newer technology called tomosynthesis mammography (3D). The goal of breast cancer screening is to find breast cancer early when it may be easier to treat. Researchers are doing this trial because they do not know if 3D is better than 2D mammography for breast cancer screening.

Dr. Lynn Baxter, the principal investigator of TMIST at NH, has been a champion of this study and its objectives since it was announced by ECOG-ACRIN and the NCI. Northside and our partners in the Georgia National Cancer Institute Community Oncology Research Program (GA NCORP) grant have enrolled 1244 participants on TMIST, with 431 of those participants enrolled at Northside Hospital. Through these efforts, GA NCORP has been recognized nationally for its contribution to this study.

Please contact the NH Central Research Department at 404.303.3355 or research@northside.com with any questions related to the TMIST study.

Around Our Campuses and Community

Innovative Lung Nodule Clinic Opens at Cherokee Campus

While most lung (or pulmonary) nodules are benign, in some cases these small masses of tissue in the lungs can be an early indicator of lung cancer. More often than not, lung nodules go undetected because they do not cause symptoms; however, they can be found incidentally during a CT scan or X-ray.

The primary purpose of the new Lung Nodule Clinic at Northside Hospital (NH) Cherokee is to expedite the evaluation of lung nodules in an effort to detect cancer early, which leads to better outcomes. “Early detection is a key factor in achieving positive outcomes in cancer care and treatment,” said Akhil Vallabhaneni, MD, MS. “Through our work in the Lung Nodule Clinic, we can diagnose and stage lung nodules more quickly and as a result, our patients can begin their treatment regimens sooner rather than later.”

Once a lung nodule is discovered, the multidisciplinary team of specialists, including interventional pulmonologists, radiologists, thoracic surgeons and oncologists at NH Cherokee collaborate to efficiently provide an individualized diagnosis and treatment plan that is implemented by the clinic coordinator. As the main point of contact for the patient, the clinic coordinator works to assist with scheduling all necessary appointments, liaise between the clinical staff and patient, provide educational materials and manage referrals for support services, if needed.

Most patients are referred to the Lung Nodule Clinic after a suspicious nodule is detected on chest scans; however, patients interested in a second opinion on a previous scan may make an appointment as a self-referral. For more information or to refer a patient, please call the Lung Nodule Clinic information line at 404.845.5050.

Recent FDA Oncology Drug Approvals

<table>
<thead>
<tr>
<th>Drug</th>
<th>Disease</th>
<th>Comapny</th>
<th>Approved for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belantamab mafodotin-bmf (BLENREP)</td>
<td>Multiple myeloma (MM)</td>
<td>GlaxoSmithKline</td>
<td>Adults with relapsed or refractory (R/R) MM who have received at least four prior therapies, including an anti-CD38 monoclonal antibody, a proteasome inhibitor, and an immuneomodulatory agent</td>
</tr>
<tr>
<td>Oral combination of decitabine and cedazuridine (INQOVI)</td>
<td>Myelodysplastic syndromes (MDS)</td>
<td>Taiho Oncology</td>
<td>Adults with MDS</td>
</tr>
<tr>
<td>Brexucabtagene autoleucel (TECARTUS)*</td>
<td>R/R mantle cell lymphoma (MCL)</td>
<td>Kite, a Gilead Company</td>
<td>Adult patients with R/R MCL</td>
</tr>
<tr>
<td>Lurbinectedin (ZEPZELCA)*</td>
<td>Metastatic small cell lung cancer (SCLC)</td>
<td>Pharma Mar S.A.</td>
<td>Adult patients with metastatic SCLC with disease progression on or after platinum-based chemotherapy</td>
</tr>
</tbody>
</table>

*Accelerated approval
**Around Our Campuses and Community**

**Northside Hospital Named “High Performing” by US News & World Report**

Northside Hospital (NH) Atlanta was rated high performing in cancer, colon cancer surgery and lung cancer surgery by US News & World Report for 2020-2021. NH Forsyth and Gwinnett were also rated high performing in colon cancer surgery. For more information, visit health.usnews.com/best-hospitals/rankings.

**Provider Features**

**John E. Moore, MD**, chief of Thoracic Surgery and medical director of the Lung Cancer Program at Northside Hospital and Northside Hospital Cancer Institute retired on September 1, 2020 after nearly 40 years of practice in the Atlanta Region. He is board-certified in both general surgery and cardiothoracic surgery and his main interest is the treatment of lung and esophageal malignancies.

He has been instrumental in bringing new techniques to the Atlanta Region and to the state of Georgia as a whole. In fact, Dr. Moore was the first physician in Atlanta to perform a mitral valve repair using the Carpentier technique. He is a graduate of the University of Louisville, School of Medicine and completed his internship, general surgery residency and cardiothoracic surgery residency at Emory-affiliated hospitals. Please join us in thanking Dr. Moore for his years of service at NH and congratulating him on his retirement!

**Benedict Benigno, MD**, medical director of the Gynecologic Cancer Program at Northside Hospital and Northside Hospital Cancer Institute, retired on September 1, 2020. He practiced for 50 years in the Atlanta Region, founding the practice University Gynecologic Oncology and serving as president. In 1999, he founded and served as CEO at the Ovarian Cancer Institute at Georgia Institute of Technology, School of Biology. He is board-certified in gynecology and gynecologic oncology. He has been a champion of ovarian cancer research, serving as principle investigator in numerous clinical trials. Please join us in thanking Dr. Benigno for his years of service at NH and congratulating him on his retirement!

**Justin Austin, PharmD, MBA** is the new director of pharmacy at Atlanta Cancer Care. He received his PharmD from Mercer University and MBA from University of West Georgia. He is passionate about quality, collaboration and the patient experience.

**Harpaul (Paul) Gill, MD** is a hematologist and medical oncologist now practicing at Atlanta Cancer Care. Dr. Gill specializes in treating patients with lung cancer, melanoma, genitourinary cancer, lymphoma and benign hematology. He is board-certified in internal medicine. Dr. Gill recently completed his fellowship in hematology and medical oncology at Emory University, where he was able to serve a broad patient population and gain experience in the social and psychological aspects of cancer care.

**Andrew Pridjian, MD** is a urologist now practicing at Urology Specialists of Atlanta. Dr. Pridjian specializes in advanced robotic procedures and urologic oncology. His special interests include the treatment of prostate bladder, kidney, adrenal and testicular cancer, as well as urinary tract reconstruction and retroperitoneal tumors. Prior to joining Urology Specialists of Atlanta, Dr. Pridjian completed a prestigious fellowship in advanced robotics and urologic oncology at the University of Southern California in Los Angeles.

**Did you know that Northside has a twitter page for providers?**

You can follow it at @NorthsideGaMD
Continuing Education and Community Events

CONTINUING EDUCATION

American College of Surgeons Clinical Congress 2020 – Virtual
October 3-7, 2020
facs.org/clincon2020/register

Cardio-Oncology: Advancing the Care of the Oncology Patient
October 22, 2020, from 6-7 p.m.
northsidegwinnett.zoom.us/meeting/register/ tJYuCumspz0oE9weltxSbi6qEhd1RI-PuLEKO

Atlanta Lung Cancer Symposium 2020 – Virtual
November 7, 2020 from 7:55 a.m.-4 p.m.
tinyurl.com/2020ALCS

Atlanta Multiple Myeloma Symposium 2020
at InterContinental Hotel Buckhead Atlanta
December 12, 2020 from 8 a.m.-1:40 p.m.
tinyurl.com/AMMS2020

2021 Atlanta Precision Oncology Symposium – Virtual
January 30, 2021
tinyurl.com/APOS2021

CANCER SCREENING & PREVENTION

Prostate Cancer Screening @ NHCI Radiation Oncology – Atlanta
October 15, 2020 from 5:30-8 p.m.
tinyurl.com/NHprostatescreening

American Lung Association's Freedom from Smoking Clinic
Next 6-Week Session Start Date: November 10, 2020
tinyurl.com/NHBuilttoquit

Hospital Skin Cancer Screening @ NHCI Radiation Oncology – Midtown
November 12, 2020 from 6-8 p.m.
tinyurl.com/NHskinscreening

COMMUNITY EVENTS

NHCI-Sponsored Cancer Walks/Events

Georgia 2-Day Walk for Breast Cancer – Virtual
September 21 (7 a.m.) - October 4, 2020 (1 p.m.)
itsethejourney.org

Light the Night for Leukemia & Lymphoma Society – Virtual
October 1, 2020 @ 7 p.m.
lighththenight.org/events/atlanta

LUNGevity’s eRACE Lung Cancer – Virtual
October 1-18, 2020
tinyurl.com/lungevity

Komen Greater Atlanta MORE THAN PINK Walk – Virtual
October 10, 2020 @ 10 a.m.
info-komen.org/site/TR?fr_id=8331&pg=entr

Paint Gwinnett Pink Walk/Run for Breast Cancer – Virtual
October 24, 2020
support.paintgwinnettpink.com
CommUNITY EVENTS (continued)

NHCI-Sponsored Cancer Walks/Events (continued)

2020 Atlanta Walk to End Colon Cancer @ Lee + White in Atlanta & Virtual
October 24, 2020 @ 10:00 a.m.-Noon
tinyurl.com/walktoendccatl

LUNGevity’s Breathe Deep Together Walk/Run – Virtual
October 24, 2020 @ 10 a.m.
tinyurl.com/lungevitybreathedeep

Melanoma Research Foundation’s Miles for Melanoma 5K – Virtual
October 24, 2020
join.melanoma.org/site/TR?fr_id=1575&pg=entry

Pancreatic Cancer Action Network’s PurpleStride Atlanta – Virtual
November 14, 2020
tinyurl.com/purplestrideatl

American Lung Association’s LUNG FORCE 5K Run/Walk – Virtual
November 14, 2020
action.lung.org/site/TR?fr_id=21390&pg=entry

The Great American Smokeout – Smoking Cessation Education @ NH campuses
November 19, 2020

FOUNdATION EVENT

Tennis Against Breast Cancer (Benefits the NH Breast Care Program) – Virtual
October 30, 2020 @ Noon
give.northside.com/events/tennis-against-breast-cancer/