NHCI 2018 Symposium to Focus on Multidisciplinary Approach to Gastrointestinal Cancer

The Northside Hospital Cancer Institute is pleased to host a continuing educational program focusing on a multidisciplinary approach to gastrointestinal (GI) cancers. This one-day program, which will take place Saturday August 25, 2018, at the JW Marriott Atlanta Buckhead, will feature esteemed faculty from across the US and provide state-of-the-art updates on a variety of GI cancer-related topics that will appeal to clinicians caring for patients with GI cancers. An interactive program, featuring didactic presentations, panel discussions, and case presentations, will give participants an opportunity to engage with their peers and inspire new ideas to implement in their daily practice. For more information, please visit http://nhcisymposium2018.cvent.com.

2018 Symposium Chair
Eddie Abdalla, MD, FACS
Atlanta Liver & Pancreas Surgical Specialists

2018 NHCI Planning Committee
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Nishan Fernando, MD
Georgia Cancer Specialists
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Samir Khleif, MD
Augusta University Medical College of Georgia
Augusta, GA
Fred Moeslein, MD, PhD
Sarasota Memorial Hospital
Sarasota, FL
Charles Rosen, MD
Mayo Clinic
Rochester, MN
Inderpal Sarkaria, MD
Hillman Cancer Center
Pittsburgh, PA

Agenda Highlights
• Diagnosing Upper GI Cancers: Are We Making Progress?
• Optimizing Outcomes in Hepato-Pancreato Biliary and Colorectal Cancers
• Delivering Multidisciplinary Care for GI Cancers
• Vaccine Therapy for GI Cancers
• Opportunities and Challenges of Precision Medicine in GI Cancers
IN THE NEWS: Updates for Clinicians

Practice-Changing Findings From TAILORx: Many Women With Early-Stage Breast Cancer Do Not Benefit From Chemotherapy

Adjuvant chemotherapy has been the standard of care for patients with localized breast cancer for nearly 20 years, regardless of hormone-receptor (HR), axillary lymph node, or menopausal status. Roughly 50% of breast cancers in the U.S. are HR-positive, HER2-negative and axillary node negative, yet data indicate chemotherapy is of little benefit in this population, and that in fact, most are overtreated. The 21-gene expression assay [Oncotype DX Recurrence Score (RS)] has been found to be prognostic for low and distant recurrences with low scores of 0 to 10, and predictive of chemotherapy benefit with high scores (≥26). However, it is uncertain what, if any, benefit chemotherapy may offer in patients with intermediate scores between 11 and 25.

TAILORx included women between 18 and 75 years with HR-positive, HER2-negative, axillary node-negative, breast cancer whose tumors were between 1.1 and 5 cm and who agreed to assigned chemotherapy or to be randomized based on RS. In total, there were more than 10,000 patients, 6,711 of which had RS between 11 and 25 who were then randomized to adjuvant chemo-endocrine therapy or endocrine therapy alone. The trial was powered for noninferiority with a primary endpoint of invasive disease-free survival (iDFS). Of note, the sample size was adjusted to account for non-adherence to treatment.

After a median follow-up of 90 months, the intent-to-treat population analysis of patients with RS 11 to 25 showed endocrine therapy to be noninferior to chemo-endocrine therapy for iDFS [hazard ratio (HR)=1.08; \( P=0.26 \)], distant relapse-free survival (HR=1.10; \( P=0.48 \)), relapse-free interval (HR=1.11; \( P=0.33 \)), and overall survival (HR=0.99; \( P=0.89 \)). In addition, the 9-year event rates were similar (<1% difference) between arms for all endpoints. An analysis of chemotherapy treatment interaction tests revealed significance for age but not menopausal status, tumor size, grade, or RS. The investigators concluded that adjuvant endocrine therapy is not inferior to chemo-endocrine therapy in women with HR-positive, HER2-negative, axillary node negative breast cancer and an intermediate RS.


Commentary by Cheryl Jones, MD

The results of the Phase 3 TAILORx trial are immediately practice-changing. They provide prospective validation for oncologists to confidently individualize treatments for women with node-negative, HER2-negative, estrogen receptor (ER)-positive breast cancer. With increased mammographic screening, more women are diagnosed with early-stage, node-negative breast cancer. Historically oncologists have relied on clinicopathologic features to lead the discussions with women regarding the potential benefit of chemotherapy. The Oncotype Recurrence Score provides prognostic information regarding the risk of recurrence as a continuous function from 0–100; at high range scores (>25), it predicts the benefit of chemotherapy.

At the time of design of the trial, there remained uncertainty about the benefit of chemotherapy in women with mid-range scores, defined as 11–25. Approximately two-thirds of women newly diagnosed with node-negative ER-sensitive breast cancer meet the clinical criteria to consider chemotherapy and have a mid-range Recurrence Score. Although the TAILORx trial permitted node-negative patients with primary tumors up to 5cm, the majority of enrolled patients had tumors <2cm (T1), similar to mammographically diagnosed patients in the community. The results will be highly impactful for women over 50 years of age with early-stage breast cancer and a RS of ≤25, since they can avoid chemotherapy and be effectively and confidently treated with endocrine therapy and experience a good outcome. For women <50 years old, representing more than 20% of the overall population, an unplanned exploratory analysis noted the chemotherapy benefit was seen at a slightly lower score of 20. In this subset, an absolute benefit of approximately 5% favoring chemotherapy was noted in women with scores 20–25. These results will require more research to explain this finding; the possibility of chemotherapy-induced accelerated menopause has been raised.

One very critical and practical point that must be emphasized to patients will be the importance of adherence to adjuvant hormone therapies, because favorable outcomes are in the setting of adjuvant hormonal therapies. Oncologists must also pay close attention to their patients’ adherence and side effect management for optimal clinical survival, patient outcomes, and quality of life.

New Insights into Hereditary Cancers from ASCO 2018 by Katie Lang, MS, CGC

One of the most important developments from the 2018 ASCO Annual Meeting was the finding that more patients have Lynch Syndrome (LS) than previously thought. LS is a hereditary cancer syndrome first described by Dr. Henry Lynch in 1967. Historically, the cancers most often seen in LS families are colon and uterine. Lynch-associated tumors have long been shown to exhibit microsatellite instability (MSI). Effectiveness of immunotherapy, particularly on MSI-high (MSI-H) tumors, has led to MSI being analyzed on a broader range of tumors.

One study presented at ASCO included 15,000 tumors from various disease sites, all analyzed for inherited LS mutations. Of these, 1,025 tumors had moderate (MSI-I) or MSI-H. From this same group, 18% of the patients had Lynch syndrome. The surprising result was that of those individuals who had an MSI-I or MSI-H tumor and also had LS, only 25% of these tumors were colon and uterine. Another 50% of the MSI-H tumors were disease sites not previously considered part of the Lynch-spectrum of cancers including mesothelioma.

New Insights into Hereditary Cancers from ASCO 2018 (continued)
sarcoma, prostate, melanoma, adrenal tumors, and ovarian germ cell tumors. Importantly, 45% of the patients found to have LS would not have met traditional criteria for suspicion of Lynch.

This study has two major takeaways. First, many more patients than previously thought could benefit from MSI tumor analysis. Secondly, any patient with an MSI-H tumor should be counseled about the possibility of LS and referred to a genetic counselor for a discussion of germline testing. Patients with LS could have significant risks for second primary cancers, and just as importantly their relatives may have an opportunity to be screened more frequently, or possibly prevent certain Lynch-associated cancers through risk-reducing surgery.

Checkpoint Inhibitors Becoming Standard of Care in Lung Cancer: Results of KEYNOTE-042 and KEYNOTE-407 Presented at ASCO

Results of two large phase 3 randomized trials, KEYNOTE-042 and KEYNOTE-407, comparing chemotherapy with pembrolizumab, and anti-PD-1 immunotherapy agent, in patients with non-small cell lung cancer (NSCLC), were presented at the ASCO 2018 Annual Meeting. KEYNOTE-042 compared pembrolizumab as a single agent with platinum-based chemotherapy as first-line treatment of patients with locally advanced or metastatic NSCLC (n=1,274). Treatment consisted of a fixed dose of pembrolizumab 200 mg Q3W for ≤35 cycles or investigator’s choice of carboplatin + paclitaxel or carboplatin + pemetrexed, each administered for ≤6 cycles, with optional pemetrexed maintenance therapy for patients with nonsquamous histology. After a median follow-up of 12.8 months, pembrolizumab monotherapy demonstrated a statistically significant improvement in overall survival (OS) regardless of PD-L1 expression, with the magnitude of benefit increasing as PD-L1 expression levels increased. Overall response rates (ORR) and duration of response were higher with pembrolizumab vs chemotherapy at all levels of PD-L1 expression. Pembrolizumab was associated with less grade 3–5 adverse events (AEs; 17.8% vs 41%) despite longer treatment exposure, thereby making it an appropriate treatment option for any level of PD-L1 positivity.

KEYNOTE-407 was a randomized trial comparing carboplatin + paclitaxel (or nab-paclitaxel) with and without pembrolizumab in 559 patients with previously untreated metastatic squamous NSCLC. After a median follow-up of 7.8 months, OS (15.9 vs 11.3 months) and progression-free survival (6.4 vs 4.8 months) were significantly superior with chemotherapy + pembrolizumab versus chemotherapy alone. Moreover, these benefits were observed regardless of PD-L1 expression. ORR was also significantly higher for patients in the pembrolizumab-based arm vs chemotherapy alone (58.4% vs 35%; P=0.0004). AEs were similar between arms and consistent with the known safety profiles of pembrolizumab (with the exception of immune-mediated AEs) and the chemotherapy agents.


Commentary by Wassim Mchayleh, MD

Over the past few years, we have seen unbelievable advances in treatment of lung cancer with significant improvement in outcomes and survival, especially with the use of immunotherapy alone or in combination with chemotherapy. Targeted therapy has moved to the front line as it was shown to be superior to chemotherapy. However, targeted therapy data were in a small subset of patients, such as EGFR-positive NSCLC, which only accounts for 10–15% of lung cancers. The KEYNOTE-042 trial showed that pembrolizumab is superior to chemotherapy in patients who have a PDL-1 level >1%, which accounts for about two-thirds of lung cancers. These unprecedented findings demonstrated a better tolerated treatment that beat traditional chemotherapy and improved survival in such a large number of patients.

Squamous cell lung cancer is usually very aggressive, with less actionable targets and less treatment options than adenocarcinoma and consequently a lower survival. Results of the KEYNOTE-407 trial demonstrated that combining pembrolizumab with chemotherapy prolonged survival by almost 5 months. These findings represent the first success after many failed combination attempts over the years.

Both KEYNOTE studies, in addition to all the recent practice-changing studies, give hope to lung cancer patients and their treating oncologists. These are very exciting times, but we should never forget that smoking cessation is as important as any treatment because it prevents a very large number of lung cancers.
IN THE NEWS: Updates for Clinicians

New Standard of Care for Patients With Resected Pancreatic Cancer

At present, adjuvant therapy for patients with pancreatic cancer who have undergone an R0/R1 resection is 6 months of gemcitabine and/or a fluoropyrimidine; however, as many as three-quarters of patients relapse within 2 years, thus necessitating improved adjuvant treatments. FOLFIRINOX, a combination of oxaliplatin, irinotecan, and fluorouracil, has been shown to be more effective than gemcitabine as a first-line therapy for metastatic pancreatic cancer; thus, prompting its study in the adjuvant setting.

PRODIGE-24, a phase 3 randomized trial, compared a modified FOLFIRINOX regimen (continuous IV infusion of fluorouracil vs bolus dosing) with gemcitabine as adjuvant therapy in 481 patients with resected pancreatic cancer.1 With a median follow-up of 33.6 months, modified FOLFIRINOX demonstrated a highly statistically significant improvement in disease-free survival (DFS), the primary endpoint, as well as in overall cancer-specific and metastasis-free survival compared with gemcitabine. Although mFOLFIRINOX was associated with increased use of white blood cell growth factors and a higher frequency of adverse events—specifically diarrhea, peripheral neuropathy, fatigue, vomiting, mucositis, and hand-foot syndrome—the regimen was considered to be safe with manageable toxicities.

Based on these data, the investigators concluded that mFOLFIRINOX should be considered the new standard of care for adjuvant therapy of pancreatic cancer.


No Survival Benefit for Hyperthermic Intraperitoneal Chemotherapy (HIPEC) for Colorectal Peritoneal Carcinomatosis

Peritoneal metastases from colorectal cancer (CRC) is associated with a poor prognosis; however, in recent years, promising results have been seen with cytoreductive surgery followed by heated chemotherapy delivered to the abdomen (ie, hyperthermic intraperitoneal chemotherapy [HIPEC]). Results of a randomized trial (PRODIGE-7) comparing surgery alone or surgery followed by HIPEC in 265 patients with stage 4 CRC and isolated peritoneal carcinomatosis were presented at the ASCO Annual Meeting.1 After a median follow-up time of 63.8 months, no differences were observed between the HIPEC and surgery alone groups with respect to median OS (41.7 months and 41.2 months), 1-year OS (86.9% and 88.3%), 5-year OS (39.45 and 36.7%), and relapse-free survival (13.1 months and 11.1 months). The overall post-surgical mortality rate was 1.5% and was similar between the two arms. While the morbidity rates at 30 days were similar between treatment groups, late complications at 60 days were nearly double in patients in the HIPEC arm (grade 3-5 complications 24.1% vs 13.6%, P=0.030). The authors concluded that findings from PRODIGE-7 indicate that cytoreductive surgery alone is as effective as surgery with HIPEC.


Commentary by Nishan Fernando, MD

Long-term results after definitive pancreatic surgery remain disappointing, with the majority of patients with initially resectable disease subsequently relapsing with local and/or distant disease. Much effort over the years has been devoted to improving postsurgical outcomes by investigating the role of adjuvant chemotherapy and radiotherapy. Initial results with 5-fluorouracil-based chemotherapy and/or radiotherapy proved only modestly successful but remained a standard of care for decades through the early 2000s. Randomized studies then demonstrated the efficacy of adjuvant gemcitabine-based chemotherapy over observation alone, and most recently the superiority of combination-based therapy with gemcitabine and capecitabine over gemcitabine alone. FOLFIRINOX has proven to be more effective than gemcitabine in the metastatic setting, so the results of this adjuvant trial were eagerly awaited. The efficacy findings were quite robust with the improvements in median and 3-year overall survival, as well as disease-free survival and time to development of metastases. Subgroup analysis confirmed the superiority of FOLFIRINOX across all the prespecified subgroups as well.

FOLFIRINOX results in significant toxicities, and its safety in the adjuvant setting was unknown. The investigators used a modified version that omitted the fluorouracil bolus and lowered the irinotecan dose. Even with modifications, more patients in the FOLFIRINOX arm experienced severe side effects, although they were mostly hematologic and manageable. No toxic deaths were seen in the FOLFIRINOX arm vs one in the gemcitabine arm.

The investigators’ conclusion is a reasonable one in general, but several questions remain to be answered. As with many other malignancies, a neoadjuvant or perioperative approach may be a more effective way to treat presumed micrometastatic disease and may also be better tolerated. In the post-op setting, patient selection will be critical, and it is unclear what role delivered dose intensity may play in the efficacy of this regimen. These questions await answers, but clearly important progress has been made in the treatment of pancreatic cancer.

Commentary by Sreekanth (Kanthi) Reddy, MD

Management of peritoneal carcinomatosis remains a controversial topic in the management of metastatic colon cancer. The use of cytoreductive surgery with or without HIPEC has shown some promise in a number of trials, with a small percentage of patients achieving long-term remissions. PRODIGE-7 randomized a carefully selected group of patients to either cytoreductive surgery or cytoreductive surgery combined with HIPEC. The authors concluded that cytoreductive surgery alone resulted in equivalent overall survival in this patient population with decreased early morbidity. It is important to note that these patients were screened for distant disease. Based on currently available data, the NCCN guidelines do not recommend routine usage of HIPEC in peritoneal only metastatic colon cancer. Factors such as patient selection, disease biology, responsiveness to available chemotherapeutic agents, and surgical experience should be considered when referring patients for either surgery or a combined approach. It remains unclear as to whether the combined approach in this patient population offers benefit. Ideally, careful patient selection, referral to a high-volume center, and enrollment on clinical trials should be considered in this population of patients.
IN THE NEWS: Updates for Clinicians

Cytoreductive Nephrectomy No Longer Considered Standard of Care for Patients With Poor and Intermediate Risk Metastatic Renal Cell Carcinoma

For nearly two decades, the standard of care for patients with metastatic renal cell carcinoma (mRCC) was cytoreductive nephrectomy in addition to systemic therapy. However, the era of targeted therapies has brought the role of surgical resection into question. Multiple retrospective data sets continued to show potential benefit but was subject to tremendous selection bias. The recently published CARMENA (Cancer du Rein Métastatique Néphrectomie et Antiangiogéniques) trial prospectively compared the benefits of nephrectomy followed by targeted therapy with targeted therapy alone in patients with poor and intermediate risk mRCC by Memorial Sloan Kettering Cancer Center (MSKCC) criteria.

Patients in this randomized phase 3 trial were assigned to nephrectomy/sunitinib (n=226) or sunitinib alone (n=224). After a median follow-up of 50.9 months, sunitinib was shown to be non-inferior to nephrectomy/sunitinib with respect to overall survival (OS; 18.4 vs 13.9 months). Although there were no differences in progression-free survival or overall response rate between the two groups, a statistically significant improvement in clinical benefit rate was observed in the sunitinib arm (47.9% vs 36.6%; P=0.022). The authors concluded that cytoreductive nephrectomy should no longer be considered the standard of care for patients with poor or intermediate risk mRCC.


Commentary by Crain Garrot, MD

While results of the CARMENA trial will change our practice for most patients who present with metastatic kidney cancer that fulfill the criteria of poor and intermediate risk, there still may be a role for cytoreductive surgery for: (1) patients with good-risk characteristics; and (2) patients with significant symptoms (eg, pain or bleeding) from the main kidney mass. Therefore, the significant change to the routine approach to metastatic kidney cancer is that cytoreductive nephrectomy will be considered on a case by case basis on the merits of benefit to an individual patient rather than a treatment strategy to apply to all patients. One of the main positive aspects of this trial is that it does indicate that patients will do better with initial medical therapy if the disease is more advanced than they will with surgical therapy.

Elevating Patient Experience at NHCI

Metastatic Breast Patients – NCCN Update for Genetic Counseling and Testing by Katie Lang, MS, CGC

The National Comprehensive Cancer Network (NCCN), recently updated their guidelines to recommend consideration of germline (inherited) BRCA testing for all women with HER2-negative MBC. This is a shift in the way guidelines around genetic testing are considered. Most BRCA testing recommendations stem from research into the likelihood that a patient carries a genetic mutation. Historically, this included women with early onset breast cancer, men with breast cancer, or those with multiple cases of breast cancer in their family. This new guideline represents one of the first times that germline BRCA testing is recommended based on its impact on a patient’s treatment, rather than on their likelihood of testing positive. Due to the data surrounding the effectiveness of PARP inhibitors on HER2-negative MBC in BRCA-positive patients, these guidelines were updated to recommend consideration of BRCA testing for this population.

PARP inhibitors are a targeted molecular therapy shown to be most effective in tumors with homologous recombination deficiency (HRD). The BRCA1 and BRCA2 genes play a major role in the homologous recombination (HR) pathway inside cells. The job of the HR pathway is to help repair DNA damage, particularly double-stranded breaks. Our DNA is shaped like a twisted ladder, with strands on each side connected by nucleotides. If both strands are damaged, the BRCA proteins help to repair this damage. PARP is another protein that also repairs DNA damage, only instead of double-stranded breaks, these proteins help repair single-stranded breaks. Therefore, a tumor with HRD (ie, no working BRCA genes) has no ability to repair double stranded DNA breaks. If a drug is then given which also keeps the PARP protein from working, aka, a PARP inhibitor, then single stranded breaks cannot be repaired and will become double-stranded breaks which also cannot be repaired. This much unrepaired damage is then lethal to the tumor cell. Only the cancer cells will have no functioning BRCA protein so this type of therapy can be targeted to work primarily on cancer cells unlike traditional cytotoxic chemotherapy that widely impacts healthy cells as well. Almost all tumors that develop in an individual with an inherited BRCA mutation show HRD, and therefore these patients are good candidates for PARP inhibitors.

Even though most people with MBC do not have inherited BRCA mutations, there is enough of a benefit of this new line of therapy for NCCN to recommend consideration of germline BRCA for these patients in order to identify those who may benefit. This is a very exciting development for women and men with advanced breast cancer because it may open the door to new treatment options.

In response to this new guideline, the Northside Cancer Genetics Program has made appointments immediately available to MBC patients, at all in-person locations (Atlanta, Forsyth, Cherokee, Holly Springs and Stockbridge). As with all genetic testing for breast cancer risk, the NCCN strongly recommends thorough pre- and post-test genetic counseling, ideally with a genetics professional like a genetic counselor. The advancements and expansion of the scope of testing options can be confusing for patients and complicated to interpret.

Northside has a large cancer genetics program with board-certified genetic counselors who can fully evaluate patient’s personal and family history, discuss all testing options, handle insurance pre-verifications, review costs and disclose and interpret results for the patient and their entire family.
Elevating Patient Experience at NHCI

CAR T-Cell Therapy Now Available for Treatment of Certain Types of Non-Hodgkin Lymphoma

The Northside Hospital Cancer Institute is proud to announce the availability of CAR T-Cell therapy. Within the NHCI’s capacity as an authorized treatment center for Yescarta®, axicabtagene ciloleucel, a CD19-directed genetically modified autologous T-cell therapy (also known as CAR T) can now be administered for patients with certain types of Non-Hodgkin lymphoma.

Yescarta® is for adult patients who have certain types of relapsed or refractory large B-cell lymphoma after two or more types of treatment, and CAR T-Cell therapy is a promising personalized immunotherapy treatment that uses a patient’s own T-cells to eliminate malignant cancer cells.

Clinical Trials and Research

NHCI Social Workers Present at Association of Oncology Social Work 2018 Conference

NHCI social workers, Bryan Miller, LCSW, OSW-C, and Katherine Easton, LCSW, OSW-C, recently presented posters at the Association of Oncology Social Work (AOSW) 34th Annual Conference held May 30–June 1, 2018, in Atlanta. Bryan Miller’s presentation focused on findings from a pilot study aimed to compare the effectiveness of two methods of survivorship care plan delivery to breast cancer patients completing treatment. Katherine Easton’s presentation focused on an innovative community-based, peer-led educational program, Chemoflage, for women undergoing chemotherapy treatment. Both posters were received with great interest, and NHCI is proud to share our innovative social work programs with the greater cancer community.

Around Our Campuses and Community

Northside Hospital Awarded National Lung Cancer Certification

Northside Hospital has earned The Joint Commission’s (TJC) Gold Seal of Approval® for Lung Cancer Disease-Specific Care (DSC) Certification for a second consecutive survey. “Northside is currently one of five hospitals in the country that has received The Joint Commission Disease-Specific Care Certification for lung cancer and the only program that focuses on thoracic surgical care,” said Dr. Howard Silverboard, pulmonologist and physician lead for Northside’s Lung Cancer DSC program. “This recognition is a remarkable testament to the hard work and commitment of the entire lung cancer team, consisting of surgeons, pulmonologists, specialized nursing care, nurse navigators, respiratory therapists and rehabilitation therapists.”

NHCI offers a comprehensive continuum of lung cancer care, from low-dose computer tomography lung cancer screening, to a full range of treatment options, including minimally invasive robotic and advanced technologies that yield some of the most successful results in the country. Northside also embraces molecular-based treatment which targets individual genetic mutations in order to spare healthy cells and reduce side effects, and provides a wide array of supportive care services.

The TJC Gold Seal of Approval® is a symbol of quality that reflects an organization’s commitment to providing safe and effective patient care. Northside remains the first hospital in Georgia to receive the award for lung cancer. Northside received its first two-year lung cancer DSC Certification after undergoing a voluntary and rigorous on-site evaluation in June 2016 and demonstrating compliance with nationally-developed standards for lung cancer care. Clinical practice guidelines and performance measures were also assessed. The hospital was recertified in June 2018. For more information about lung care at Northside Hospital Cancer Institute, visit northside.com/lungcancer.

In an effort to continuously provide our patients with excellent service, Northside Cherokee Infusion Center now offers weekend hours with CADD Pump Support!

SATURDAY and SUNDAY from 7:00 am to 3:30 pm
### Around Our Campuses and Community

**NHCI Multidisciplinary Care Conferences**

NHCI has Multidisciplinary Cancer Conferences available for a range of cancer sites. Cancer Conferences offer physicians the opportunity to collaborate on prospective and/or challenging cases to formulate a treatment plan based on the latest research and evidence-based practice.

The benefits of participating in cancer conferences:

- A multidisciplinary team approach to planning and evaluating the care of patients with cancer in accordance with national guidelines (eg, NCCN).
- Review and discuss imaging for diagnosis, staging, and follow-up, including discussion of any barriers a patient may be experiencing and strategies for overcoming those barriers.
- Review pathology, identify appropriate molecular testing strategies to support individualized care, and promote AJCC staging in discussion of prognostic factors in patients with cancer.
- Review and assess standard and emerging therapeutic options for surgical management, radiotherapy and systemic therapies in managing malignancy, with special focus on clinical trial availability and other research opportunities.

A total of 11 disease-specific cancer conferences are in existence. For more information email cancer.conference@northside.com

#### Multidisciplinary Conference Schedule

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<thead>
<tr>
<th>Disease</th>
<th>Frequency</th>
<th>Time</th>
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<tbody>
<tr>
<td>Breast Cancer</td>
<td>Weekly, Monday: 1st, 3rd, 5th, 2nd, 4th</td>
<td>7:00 am, 12:30 pm</td>
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<tr>
<td>GYN Cancer</td>
<td>Weekly, Friday</td>
<td>7:00 am</td>
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<tr>
<td>Thoracic/Lung Cancer</td>
<td>Weekly, Tuesday</td>
<td>7:15 am</td>
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<tr>
<td>Neuro Oncology</td>
<td>1st, 2nd, 3rd, 5th, Friday</td>
<td>7:00 am</td>
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<tr>
<td>Melanoma / Sarcoma</td>
<td>Weekly, Wednesday</td>
<td>7:00 am</td>
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<tr>
<td>Head &amp; Neck Cancer</td>
<td>1st &amp; 3rd Tuesday</td>
<td>7:00 am</td>
</tr>
<tr>
<td>General Cancer at NH Cherokee</td>
<td>2nd Tuesday &amp; 4th Friday</td>
<td>7:30 am</td>
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<tr>
<td>Thyroid Cancer</td>
<td>Quarterly, 4th Tuesday</td>
<td>7:00 am</td>
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<tr>
<td>Colorectal Cancer</td>
<td>2nd Wednesday</td>
<td>7:00 am</td>
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<tr>
<td>Abdominal/Liver Cancer</td>
<td>1st, 3rd, 4th, &amp; 5th Wednesday</td>
<td>7:00 am</td>
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Strong growth has occurred in the number of conferences offered and the number of cases discussed. Additionally, the implementation of web conferencing using GoToMeeting has facilitated increased attendance by physicians and staff located remote to the conference site.

### Upcoming Events

#### Continuing Education (Local Events)

- **NHCI 2018 Symposium: A Multidisciplinary Approach to Gastrointestinal Cancer**  
  JW Marriott Atlanta Buckhead  
  Northside Hospital is accredited by the Medical Association of Georgia to provide continuing medical education for physicians. This live activity will be accredited for AMA PRA Category 1 Credits™.
  - Saturday, August 25  
  - 7:00 am-5:00 pm

- **Lung Cancer Prevention, Screening & Diagnostics**  
  Speakers: Venkatesh Lakshminarayanan, MD, Amber Degryse, MD, and Carolyn Weaver, MD.  
  Tam’s Backstage, 215 Ingram Ave., Cumming, GA  
  - Wednesday, August 29  
  - 6:00-8:00 pm

- **2018 GASC0 Annual Meeting and Best of ASCO®**  
  - The Hotel at Avalon, Alpharetta, GA  
  - Friday-Saturday, September 14-15

- **Georgia Cancer Specialists Oncology Clinical Practice Guidelines**  
  - Georgia International Convention Center  
  - 4:00-9:00 pm

- **Lung Force Expo**  
  - Peachtree City Hotel and Conference Center  
  - Friday, September 28

- **Breast Cancer Staging Lecture**  
  Speaker: Ingrid Mayer, MD from Vanderbilt  
  Northside Hospital 980 Building Auditorium or via GoToMeeting  
  - Thursday, October 11  
  - 7:30-8:30 am

#### Cancer Screening and Prevention

- **Prostate Cancer Screening**  
  - Northside Alpharetta  
  - Thursday, August 23  
  - 5:30-8:00 pm

- **Community Prostate Screening**  
  - Latin American Association & Misión de Cristo Rey  
  - 3349 Buford Hwy NE, Suite 28C, Atlanta  
  - For information please call (404) 531-4444  
  - Saturday, August 25  
  - 10:00 am-1:00 pm

- **Smoking Cessation Session 5**  
  - various locations near Northside Hospital campuses & via web  
  - Tuesday, September 11 to Tuesday, October 16

- **Skin Cancer Screening**  
  - Northside Atlanta  
  - 6:00-8:00 pm

#### Community Events

**Frankly Speaking About Cancer: Metastatic Breast Cancer**  
Please r.s.v.p. (404) 843-1880

- **Tuesday, August 28,**  
  - 5:30-7:00 pm - light dinner and lecture  
  - Featured speaker: Kristina Bowen, MD  
  - Georgia Cancer Specialists, Affiliated with Northside Hospital  
  - Location: Cancer Support Community Atlanta,  
    5775 Peachtree Dunwoody Rd., Ste. C-225, Atlanta

- **Thursday, September 13,**  
  - 6:00-6:30 pm - dinner  
  - 6:30-7:30 pm - lecture  
  - Featured speaker: Amanda Zelnak, MD, MSc  
  - Atlanta Care Center, affiliated with Northside Hospital  
  - Location: Tam’s Backstage, 215 Ingram Ave., Cumming
Community Events (continued)

<table>
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<tr>
<th>Event</th>
<th>Date</th>
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<tbody>
<tr>
<td>Prostaware Blue Ties Event</td>
<td>Saturday, September 8 11:30 am</td>
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<tr>
<td>Ritz-Carlton Buckhead</td>
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<tr>
<td>Team Maggie 5K/10K</td>
<td>Saturday, September 15 7:30-10:30 am</td>
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<td>King’s Court Chapel in Roswell</td>
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<td>Teal Trot 5K Walk/Run at Chastain Park</td>
<td>Saturday, September 15 8:00 am – check-in</td>
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<td></td>
<td>10:00 am – Run/Walk start</td>
</tr>
<tr>
<td>Atlanta Cancer Care Foundation, A Taste of Hope</td>
<td>Thursday, September 20 6:30 pm</td>
</tr>
<tr>
<td>The Grand Salon at the Fox Theatre</td>
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<tr>
<td>Northside Hospital Fall Golf Classic</td>
<td>Monday, September 24 8:00 am</td>
</tr>
<tr>
<td>Hawks Ridge Golf Club</td>
<td></td>
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<tr>
<td>Benefitting the Northside Hospital Prostate Cancer Program</td>
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<tr>
<td>Georgia 2-Day Walk for Breast Cancer</td>
<td>Saturday-Sunday, September 29-30</td>
</tr>
<tr>
<td>Starting line: Atlanta Marriott Marquis</td>
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<tr>
<td>Wine Women &amp; Shoes</td>
<td>Sunday, September 30 2:00-5:00 pm</td>
</tr>
<tr>
<td>Grand Hyatt Atlanta in Buckhead</td>
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<tr>
<td>Proceeds from WW&amp;S benefit the Leukemia and Women’s Cancer Programs at the Northside Hospital.</td>
<td></td>
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<tr>
<td>Tennis Against Breast Cancer</td>
<td>8:00 am start</td>
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<tr>
<td>Benefits the Northside Hospital Breast Cancer Program</td>
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<tr>
<td>Forsyth - Forsyth/Lanier Tech Conference Center</td>
<td>Friday, October 5</td>
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<tr>
<td>North Fulton - Atlanta Athletic Club</td>
<td>Friday, October 19</td>
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<tr>
<td>Cherokee - Cherokee Conference Center</td>
<td>Friday, October 26</td>
</tr>
<tr>
<td>Leukemia &amp; Lymphoma Society Light the Night</td>
<td>Saturday, October 6</td>
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<tr>
<td>Piedmont Park</td>
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<tr>
<td>Colon Cancer Alliance Undy Run</td>
<td>Saturday, October 27</td>
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<tr>
<td>Howell Memorial Park</td>
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</tbody>
</table>

For more information or to answer any questions, call NHCI at (404) 531-4444

NHCI 2018 SYMPOSIUM
A Multidisciplinary Approach to Gastrointestinal Cancer
AUGUST 25, 2018 | JW Marriott Atlanta Buckhead
FOR INFORMATION & REGISTRATION, VISIT
NHCisymposium2018.cvent.com

ANNOUNCING A BEAUTIFUL PARTNERSHIP.
Northside Hospital Cancer Institute is proud to be the Medical Partner of the Susan G. Komen Atlanta 3-Day, a 60-mile walk that's making a real difference in the fight against breast cancer. In 2016, Susan G. Komen announced a Bold Goal—to reduce the current number of breast cancer deaths by 50% in the U.S. by 2026. That's why we walk, and why we raise money—to make that goal a reality.

Join the team of medical professionals who provide care and support to the walkers in a mobile medical unit, on the route, as well as in camp. You will put your physical capabilities, your diligence and your work ethic through an endurance test, but you will be rewarded in ways that, perhaps, you've never imagined.

Before you commit to joining the Medical Crew, please make sure you are at least 18 years old and able to:

• Attend a few hours of training the Thursday before the event
• Arrive before the walkers early Friday morning
• Sleep in camp, in the special crew section, for the two nights of the event
• Provide a valid, in-state Physician’s, Nursing or EMT license and BLS/CPR card OR provide a valid in-state Athletic Trainer, Chiropractic or Physical Therapist license
• Take direction from the event Medical Director and Medical Captain

Register for the Medical Crew at http://www.the3day.org/site/TR/2018/General?fr_id=2011&pg=entry, choose “Individual Registration” shown at the top and then the “Crew” option. For free registration, please enter the code HSCOMP.

For more information, contact Libby at lriordan@event360.com or 800-996-3DAY