Contra Costa Regional Medical Center
Cancer Program
Annual Report
2010
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CCRMC RECEIVES OUTSTANDING ACHIEVEMENT AWARD FROM THE COMMISSION OF CANCER

It was announced in March that CCRMC’s Cancer Program received the Outstanding Achievement Award from the Commission on Cancer. This honor is awarded to cancer programs that “strive for excellence in providing quality care to cancer patients.” Contra Costa Regional Medical Center is one of only four programs in California to obtain this honor. The Cancer Program was successfully reaccredited in 2009 with no deficiencies and six commendations in the areas of cancer-related improvements, outcome analysis, quality of NCDB submission, clinical trial accrual, prevention and early detection, cancer registry data timeliness and quality of data submission. Many of the projects we have been involved in are included in this Annual Report.

Table 1  Number of Cancer Diagnoses

WHAT’S NEW IN 2009:

2009 was a year of dramatic growth within the oncology department. We welcomed full time oncologist Lili Wang, MD, who joined us in July from Northwestern University in Chicago. We continue to expand with the growing number of patients, and currently, between physicians and nurse practitioners have 18 oncology clinics per week. The number of cancers diagnosed at our facility in 2009 increased almost 30% compared to 2008. Since 2000, our caseload has increased by 50%. Recently, we are seeing a significant increase in the number of patients transferring care to our facility because of loss of insurance.

Our infusion center has also seen extraordinary growth in the number of patients treated. When our new infusion center opened in 2001, we treated an average of 14 patients per day, and we now see approximately 26 patients daily.
ABNORMAL BREAST FINDING TO TISSUE IMPROVEMENT PROJECT (ABFTIP)

In April of 2008, Dr. James Rael, Darrell Williams and Dianne Dunn-Bowie generated a multidisciplinary team to evaluate the process and identify how we could improve our diagnostic evaluation of patients with abnormal mammograms. The group consists of radiologists, radiology technicians, nurses, physicians, nurse practitioners, and safety & performance improvement staff. The group began with a baseline of 0% of patients getting a Breast Health Provider appointment within 7 days of the finding of an abnormal mammogram. It has been able to significantly improve upon this, to a current average of 93% of the patients being seen by a Breast Health Provider within 7 days of the abnormal mammogram. The group was also able to improve the time to tissue diagnosis, starting with a baseline of 0% to a current rate of 43% of the patients receiving the appropriate follow-up biopsy within 14 days and 100% receive the intervention within 17.3 days. Prior to the intervention, the average evaluation took 60 days.

Table 2
Percent of Patients with Abnormal Mammograms (Breast Health Appointment in ≤ 7 days)

Table 3
Percent of Patients with Abnormal Mammograms (Biopsy/Resolution in ≤ 14 days)
STATE OF THE ART RECTAL SURGERY
The surgery department in collaboration with the pathology and John Muir Medical Center established a project to begin performing total mesorectal excision surgeries for rectal cancer patients. This new form of surgery allows more deep tissue to be taken and sampled, thus reducing the local recurrence rate and assuring patients the best possible outcome.

CLINICAL TRIALS
In 2009, we welcomed a new partnership with the Bay Area Tumor Institute (BATI). BATI is one of 50 federally supported Community Clinical Oncology Programs in the United States. The primary purpose of this program is to bring clinical trials that are often only available at university hospitals to the community hospital setting. The Institute operates as a non-profit California corporation, providing cancer services that no single hospital could provide on a cost effective basis. The BATI program provides a wide array of free services and programs that enable cancer patients to obtain care that is comparable to the best care offered anywhere in the United States. Our partnership affords our patients the opportunity to be some of the first patients to receive new drugs that may eventually become standard of care treatment for their disease. We now have a full time clinical trials associate who screens all new cancer patients for protocol eligibility, coordinates pre-study tests, distributes investigational drugs, submits all treatment and follow-up data, reports all serious adverse events and sits on the Investigational Review Board.

In 2009, at CCRM we enrolled 10% of our patients onto clinical trials (this compares to approximately 3% Nationally). One of the major limitations and criticisms of cancer research in this country is the lack of diversity of patients enrolled. Our diverse patient population in combination with our new partnership with BATI enables us to include many minority patients in clinical trials. In 2009, approximately 60% of the clinical trial participants at Contra Costa Regional Medical Center were minorities. This far exceeds the national average, and is a critical step in advancing our knowledge as we learn more about the biology of cancer and its different behavior in different ethnic populations.

A list of the current clinical trials available at our institution is provided at the end of this report.
BAY AREA TUMOR INSTITUTE (BATI) CONTRA COSTA REGIONAL MEDICAL CENTER (CCRMC)
PATIENT ASSISTANCE PROGRAMS PROJECT

One of the most exciting additions to the cancer program this year is the BATI CCRMc Patient Assistance Program. This project is designed to help the Medical Center substantially reduce the annual hospital-borne cost of selected therapeutic agents it provides to uninsured patients receiving care in the Cancer Center. BATI employee Nancee Hirano researches patient assistance programs from various pharmaceutical and bio-pharmaceutical companies to obtain free medications and ensures that these patients receive the medications deemed appropriate by their physicians regardless of insurance status. She provides logistical support by identifying eligible patients, processing of various documents for successful enrollment in the programs, tracking to ensure the medications are received by the Medical Center, and other duties critical to the success of this Project. In the first five months of operation, the Project has enrolled 35 patients for a cost recovery to the hospital of almost $340,000 in otherwise non-reimbursed chemotherapeutic and biotherapeutic drugs.

**Patient assistance program saved almost $340,000 in drug costs in the first six months of operation.**

PALLIATIVE CARE GRANT

In 2009, Contra Costa Regional Medical Center received a 2 year grant from the California Healthcare Foundation to fund a palliative care consult service. Under the leadership of Dr. Julie Freedman, a multidisciplinary team was established to meet with families of inpatients with complex medical and social issues who need extra support. The team generally consists of a clinician (MD or FNP), a pharmacist, a psychiatry/psychology liaison, a social worker, and the patient’s nurse. The palliative care team is designed to help with issues such as symptom management, end of life care and decision making, and to help identify patient and family priorities regarding care. Meetings between the patient and family and the palliative care team are arranged as needed, and the team follows the patient through the hospitalization.
CANCER CARE AT CONTRA COSTA REGIONAL MEDICAL CENTER

Cancer Registry Report

Contra Costa Regional Medical Center’s Cancer Registry is responsible for data collection and hospital compliance with the State of California’s Mandatory Reporting Code pertaining to all cases of cancer seen at this hospital. Abstracts on every case of reportable cancer are completed and sent to the regional collection center, the Northern California Cancer Center. It is this data that is used for professional, state and national studies of incidence, treatment and survival.

The Cancer Registry reported 352 new analytic cases in 2009, up significantly from 232 in 2000. Breast cancer cases continue to outnumber lung cancer cases this year. Thus, we have focused our in-depth report on breast cancer.

Contra Costa Regional Medical Center’s medical staff has access to patient data in the Cancer Registry for use in audits and special studies. The Registry can provide analyses of patients by tumor site, year of diagnosis, treatment modalities, recurrence and other data as needed. Staff is strongly encouraged to make use of this rich data source. Please contact the Cancer Registry at 925-370-5229.

Table 4  2009 Cancer Incidence by Primary Site

<table>
<thead>
<tr>
<th>Tumor Site</th>
<th>2009 Incidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head &amp; Neck</td>
<td>24</td>
</tr>
<tr>
<td>Esophagus</td>
<td>25</td>
</tr>
<tr>
<td>Stomach</td>
<td>5</td>
</tr>
<tr>
<td>Colorectal</td>
<td>5</td>
</tr>
<tr>
<td>Pancreas</td>
<td>3</td>
</tr>
<tr>
<td>Lung</td>
<td>12</td>
</tr>
<tr>
<td>Melanoma</td>
<td>7</td>
</tr>
<tr>
<td>Breast</td>
<td>9</td>
</tr>
<tr>
<td>Uterus</td>
<td>10</td>
</tr>
<tr>
<td>Ovary</td>
<td>19</td>
</tr>
<tr>
<td>Prostate</td>
<td>16</td>
</tr>
<tr>
<td>Bladder</td>
<td>4</td>
</tr>
<tr>
<td>Kidney</td>
<td>5</td>
</tr>
<tr>
<td>Brain</td>
<td>3</td>
</tr>
<tr>
<td>Hodgkin’s lymphoma</td>
<td>11</td>
</tr>
<tr>
<td>Non Hodgkin’s lymphoma</td>
<td>5</td>
</tr>
<tr>
<td>Multiple Myeloma</td>
<td>11</td>
</tr>
<tr>
<td>Leukemia</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
</tr>
</tbody>
</table>
AGE AT DIAGNOSIS:
At Contra Costa Regional Medical Center, we continue to see a younger population than that seen throughout the county. Many of our patients have young children, and often lack social support and transportation, which adds a great deal of complexity to their treatment planning.

Table 5
Age Group of All Sites Cancer Diagnosed in 2000 – 2007
Contra Costa Regional Medical Center –vs– National

PATIENT ETHNICITY/RACE AT CCRMC
Our patients differ significantly from the country as a whole with fewer Caucasian, non-Hispanic patients and many more African Americans, Hispanic and Asian ethnicities. This reflects both the diversity of the population in the Bay Area as well as the disproportionate burden of lack of health insurance among people of color.
HEALTH DISPARITY IN CANCER CARE

Cancer remains the number No. 2 killer of Americans. Investment in clinical cancer research has paid off. With emerging new therapies, cancer mortality rates have declined by 15% since 1990. Patient quality of life has improved dramatically. We are entering an era of personalized cancer medicine, in which treatment can be tailored to the unique genetics of the individual patient. However, there remains inequality in access to these advances in therapies. In fact, multiple studies have shown that there is a difference in cancer care among different ethnic groups, with minorities carrying significantly worse prognosis when compared with Caucasians.

Recognizing disparity in cancer care and believing in equal care, the American Society of Clinical Oncology (ASCO) made special recommendations in 2009 to address the issue. The guidelines for reducing cancer care disparities in the United States include:

- **Increasing research** on the differences in quality of care provided to minority populations compared with white patients and the factors contributing to poorer quality of care.

- **Increasing minority enrollment** into clinical trials so that critical questions can be answered about differences in cancer progression and treatment in minority populations.

- **Developing policies** to guarantee equal access to quality health care, with emphasis on reducing insurance and economic barriers to cancer care.

- **Stimulating diversity in the oncology workforce** to provide more culturally appropriate care to minority patients and increase the number of oncologists who practice in underserved areas.

- **Highlighting disparities in cancer care** at ASCO scientific meetings and educational sessions and in member communications.

At Contra Costa Regional Medical Center, we offer cancer care to a culturally and ethnically diverse population of patients. The ethnicity of our patients diagnosed with cancer from 2000-2007 is significantly higher in percentage of minority patients receiving care at CCRMC compared to all hospitals nationally.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>CCRMC Percentage</th>
<th>Nationally Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>18%</td>
<td>10%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>21%</td>
<td>4%</td>
</tr>
<tr>
<td>Asian</td>
<td>11%</td>
<td>2%</td>
</tr>
</tbody>
</table>
At CCRCMC, we not only offer equal access to care for all patients, but we also encourage patients to enroll in clinical trials. In 2009, we enrolled 50 patients into clinical trials. 12 were Hispanic (24%), 11 were African American (22%), 7 were Asian (14%) and 20 were Caucasian (40%).

Table 7  Race/Ethnicity Clinical Trial Enrollment in 2000 – 2007
Contra Costa Regional Medical Center

- Asian: 40%
- Black: 24%
- Hispanic: 14%
- White: 22%
Breast cancer is the most common cancer and the second leading cause of cancer death in women. Breast cancer diagnosis and treatment remains in the media spotlight, and controversies regarding optimal screening and treatment continue. Through the use of clinical trials, much of what we know about the treatment of breast cancer continues to advance and be refined.

The most important known risk factor for breast cancer is age. The risk of breast cancer of women at age 40 is 1 in 1,000, compared to the risk at age 60 which is 1 in 500. Other known risk factors include genetic abnormalities BCRA 1 and BCRA 2 genes, biopsy proven atypical hyperplasia and exposure to longer years of ovulation (early menarche, late menopause, and delayed first pregnancy). Incidence of post menopausal breast cancer has decreased significantly since routine use of estrogen and progesterone to treat menopausal symptoms is no longer recommended.

Early detection is the best defense against breast cancer. Women with smaller tumors are more likely to be cured and less likely to need mastectomy and chemotherapy. Mammography remains the primary tool for screening, and has been shown to save lives, particularly in women over 50. Novel techniques using MRI and CT are available for certain complex situations, and used for screening extremely high risk women.

At CCRM C, our patient population tends to have more advanced disease at diagnosis. This can be attributed to many factors, including patient fear and lack of access to care. Often patients are not aware that they are eligible for programs to assist them with diagnosis and treatment.

Treatment of breast cancer frequently includes multiple modalities depending on medical circumstances and women’s preferences. At Contra Costa Regional Medical Center in 2009, 88% of patients with tumors less than five centimeters underwent lumpectomy with radiation and 12% underwent mastectomy. The rate of lumpectomy is variable by region in the U.S., with California being the lead offering lumpectomy to eligible women. Our rates are similar to those in other hospitals in the Bay Area.
Both lumpectomy and mastectomy are accompanied by removal of the lymph nodes under the arm (axillary node dissection). Unfortunately, this procedure can be complicated by lymphedema, a painful swelling of the arm. After five years of participating in a nationwide study through the American College of Surgeons examining sentinel node techniques, we began offering sentinel node biopsy as a routine in 2005. This will significantly decrease the number of patients who suffer from lymphedema after curative treatment for their breast cancer. Early exercise and massage program begun prior to surgery has also been shown to reduce the risk of lymphedema.

Radiation therapy is considered standard for all women undergoing lumpectomy as their primary surgery. Post operative radiation reduces the risk of cancer recurrence by 20–25%. The national goal is that 95% of women treated with lumpectomy will have radiation therapy postoperatively. In 2007, 96% of the patients treated with lumpectomy at our center underwent radiation.

Systemic therapy with chemotherapy, hormonal therapy or monoclonal antibody therapy is
frequently administered after surgery for breast cancer. Adjuvant therapy is used to kill any cells in other parts of the body to help prevent the cancer from returning at a later date. Chemotherapy is also increasingly being given neoadjuvantly, or before surgery. Many of the women we treat are enrolled in large nationwide clinical trials exploring the most effective combination of drugs.

- Either adjuvant or neoadjuvant therapy is indicated in some women with Stage I cancers, and all healthy women with Stage II, III and IV breast cancer. In 2009, 93% of women with lymph node positive breast cancer who were ER negative received chemotherapy and 100% of women under age 70 with ER negative breast cancer larger than one centimeter received chemotherapy. These percentages exceed the national guideline of 90%.

- Despite improvements in the understanding and treatment of breast cancer in the past decade, much still remains to be done. The optimal chemotherapy and hormonal regimen has yet to be clearly determined. Our recent partnership with the Bay Area Tumor Institute affords us the opportunity to actively enroll patients into clinical trials attempting to answer questions about the optimal treatment of breast cancer.

- Five-year survival rates from breast cancer are improving. Women whose cancer is confined to the breast at diagnosis have a 96% five-year survival according to the most recent SEER data. Breast cancer incidence has not significantly increased in California in the last 20 years, and mortality has declined by more than 28% due to the combined effects of better treatment and earlier diagnosis. Despite these improving numbers statewide, the number of women diagnosed with breast cancer at Contra Costa Regional Medical Center in 2009 was almost double that of previous years. This is likely due to more women being uninsured at diagnosis and more women choosing our facility for care.

**CANCER REGISTRY REPORT**

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**MEDICAL ONCOLOGY**

Medical Oncology has become an increasingly important aspect of most patients’ cancer treatment. We now recognize that cancer is a systemic disease and may not spread through the lymph nodes before finding its way to other parts of the body. Chemotherapy is standard in most patients with advanced stages of cancer and frequently given in earlier stages. Chemotherapy takes many forms, including standard chemotherapy, high-dose chemotherapy with stem cell support, biologic modifiers, immunotherapy and hormonal therapy. Chemotherapy is frequently combined with radiation therapy in order to preserve organs obviating the need for removal (such as laryngeal sparing therapy).

**RADIATION ONCOLOGY**

Radiation Oncology services are provided by four of our neighboring hospitals in the East Bay. Mt. Diablo Medical Center in Concord, Doctors Medical Center in San Pablo, and John Muir Medical Center in Walnut Creek provide radiation service to our patients, depending on convenience of location to the patient’s home. Implant radiation services are provided at Summit Medical Center in Oakland. Radiation therapists attend the weekly Cancer Conference where each of the patients needing radiation therapy are discussed and their treatment planned. All four facilities have experienced staff and are known for providing up-to-date treatment planning and service.
INFUSION CENTER
Contra Costa Regional Medical Center has a dedicated Infusion Center located in the Martinez Health Center. The unit is staffed by certified oncology nurses. In addition, social workers, financial counselors, home care specialists and dieticians are readily available. The Infusion Center is responsible for administering chemotherapy and complicated home antibiotic regimens, transfusing blood products and doing diagnostic procedures. This allows most patients to be treated as an outpatient instead of spending precious time in the hospital.

The nurses spend much of their time educating patients and their families about the therapies they are receiving. Each oncology patient is assigned to a nurse whose responsibility for teaching covers an ever increasing range of issues related to treatment. Patients are instructed on how to prevent side effects and cope with the symptoms of their cancer. Options are reviewed for dealing with pain, nausea, anxiety and sleeplessness.

Every effort is made to assist each patient in minimizing or overcoming those challenges which interfere with treatment for their disease. Transportation and child care issues become the focus of efforts to assist in enabling patients to keep every scheduled appointment. The Infusion Center staff is a highly functioning team who continuously strategize, teach and assist patients to cope with the challenges they face.

Nutritional support is a critical factor in the successful management of cancer patients. Many patients begin their treatment having lost weight prior to knowing they have cancer and others may lose weight during their treatments. All new patients are encouraged to attend special nutritional classes, which have been set up to discuss optimal diet plans. They receive verbal and written counseling on strategies for maintaining a healthy weight and good nutritional intake. Common side effects of cancer therapy that affect eating include nausea, vomiting, diarrhea, taste changes or difficulty swallowing, which can occur during radiation treatment.

NUTRITIONAL SUPPORT
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COMMUNITY/SOCIAL SERVICES
2009 was a year of dramatic growth in our patient population, both within the oncology department and the county health care system as a whole. Unfortunately, difficult economic times have led to a loss of charitable programs and services for our patients. Anna’s program for patients with metastatic breast cancer, Every Woman Counts, a free breast cancer screening and evaluation program, and patient navigators are currently unavailable.

Despite these setbacks, we continue to provide many important patient services. Rosemary Nishikawa, our medical social worker, is an intricate member of our oncology team and functions as a liaison to community service organizations. She offers information, assessment, support and counseling, especially regarding emotional adjustment to a cancer diagnosis and its treatment, matters of daily living, and the availability of community services. She routinely screens all new oncology patients and intervenes when problems arise or when referrals are made by other team members.

The Contra Costa Regional Medical Center’s Cancer Program staff is committed to providing a variety of public and professional education for the community. Upon diagnosis, patients and families meet with a member of the oncology staff as soon as possible. During this meeting, the patient and family are given the CCRM Cancer Program Personal Resource Guide, which contains information about specific cancers and treatments, side effect management, nutrition, pain, local cancer organizations and support groups.

In 2009, we initiated a chemotherapy class for all patients to attend prior to their first day of chemotherapy. Patients are taught what to expect at home after their cancer treatment, and learn about chemotherapy side effects, symptom management and when to call the doctor.

The CCRM Cancer Program collaborates with a number of organizations in the community. Three times yearly, CCRM sponsors Look Good...Feed Better programs by the American Cancer Society, in which women undergoing
Chemotherapy are taught skin care and makeup hints, and fitted for wigs.

The wellness community has a local site in Walnut Creek and provides many services to cancer patients including classes, support groups and educational material here on campus.

Contra Costa Health Services has held free screenings for breast cancer during Breast Cancer Awareness month each October for the past 10 years. Our program includes free clinical breast examination and mammography for women in Richmond, Pittsburg and Martinez. This program has been successful through the efforts of the nursing and medical staff in addition to tremendous support from Public Health and the Contra Costa Health Plan. Last year, 60 women without health insurance were screened and offered free follow-up.

**Celebration of Life Party**
The oncology staff hosted our annual celebration of life party in June. The party had a Wild West theme. Cancer survivors and their families enjoyed the food, games and music, sharing stories of their recoveries and victories. It was a time of joy and happiness that we all took pride in by sharing in the experience. Numerous enthusiastic and caring people lent a hand to make this a special party. The medical staff donated money. The Mexican food was purchased from The Mecca in Pittsburg and donated by nurses who added drinks, chips and cookies. Music was provided by three talented doctors who filled the evening with an atmosphere of celebration throughout the night. We left that night with the satisfaction and pride that so many of the wonderful staff here care to get involved with the support we offer to our patients. We all look forward to next year’s party for the celebration of life and the joy that comes from so many who participate.

**Volunteer Services**
The volunteers are an essential part of our daily life. They can be counted on to bring books to infusion patients, run important lab and pharmacy orders through the hospital, or simply brighten your day with their smile.

The Auxiliary provides patients with handmade hats, turbans and lap pads free of charge. They have also helped patients undergoing chemotherapy with their purchase of individual tape players and educational and relaxation tapes.

**Cancer Conference**
Cancer Conferences are held weekly on the first, third, fourth and fifth Thursdays of each month. Physician representatives from all disciplines attend and participate in the conference. Each patient’s case is formally presented followed by review of appropriate pathology slides and radiographs. The team of primary care providers, surgeons, radiation therapists and medical oncologists, then discuss the options available for treatment. A summary of the conclusions are documented in the patient’s chart and reviewed with the patient. This interdisciplinary conference is integral to the treatment planning for patients with cancer. All major cancer sites are presented.
**Clinical Trials Provided by BATI**

*Asterisked studies represent studies that patients were enrolled to but recently closed*

**breast cancer — neo-djuvant**

**calgb 40601**: Randomized Phase III Trial of Paclitaxel Combined with Trastuzumab, Lapatinib, or Both as NeoAdjuvant Treatment of HER2-Positive Primary Breast Cancer

**calgb 40603**: Randomized Phase II 2x2 Factorial Trial of the Addition of Carboplatin +/- Bevacizumab to NeoAdjuvant Weekly Paclitaxel Followed by Dose-Dense AC in Hormone Receptor-Poor/Her2-negative Recetable Breast Cancer

**nsabp b-40**: A Randomized Phase III Trial of Neo adjuvant Therapy in Patients with Palpable and Operable Breast Cancer Evaluating the Effect on Pathologic Complete Response (pCR) of Adding Capecitabine or Gemcitabine to Docetaxel when Administered Before AC With or Without Bevacizumab and Correlative Science Studies Attempting to Identify Predictors of High Likelihood for pCR With Each of the Regimens

**breast cancer — adjuvant**

**nsabp**: A Randomized Phase IIi Study of Conventional Whole Breast Irradiation (wBI) Versus Partial Breast Irradiation (PBI) for Women with Stage 0,i, or ii Breast Cancer

**nsabp b-43**: A Phase IIII Clinical Trial Comparing Trastuzumab Given Concurrently with Radiation Therapy and Radiation Therapy Alone for Women with HER2-Positive Ductal Carcinoma in Situ Resected by Lumpectomy

**pactt-1**: Program for the Assessment of Clinical Cancer Tests: Trial Assigning Individualized Options for Treatment: The TAILORx Trial

**calgb 40101**: Cyclophosphamide and Doxorubicin (ca x Cycles) Versus Paclitaxel (4 Cycles) as Adjuvant Therapy for Breast Cancer in Women with 0-3 Positive Axillary Lymph Nodes: A Phase IIi Randomized Study

**ctsu e5103**: A Double-Blind Phase III Trial of Doxorubicin and Cyclophosphamide followed by Paclitaxel with Bevacizumab or Placebo in Patients with Lymph Node Positive and High Risk Lymph Node Negative Breast Cancer

**ctsu n063d: altto**: Adjuvant Lapatinib and/or Trastuzumab Treatment Optimisation Study: A Randomised, Multi-centre, Open-label, Phase III Study of Adjuvant Lapatinib, Trastuzumab, Their Sequence and Their Combination in Patients with HER2/ERBB2 Positive Primary Breast Cancer

**seog 0221**: Phase IIII Trial of Continuous Schedule AC + G Vs. Q 2 Week Schedule AC, Followed by Paclitaxel Given Either Every 2 Weeks or Weekly for 12 Weeks as Post-Operative Adjuvant Therapy in Node-Positive or High-Risk Node Negative Breast Cancer.

**breast cancer — locally advance/metastatic**

**calgb 40302**: Endocrine Therapy With or Without Inhibition of EGF and HER2 Growth Factor Receptors: A Randomized, Double-Blind, Placebo Controlled Phase III Trial of Fulvestrant With or Without Lapatinib (GW572016) for Postmenopausal Women With Hormone Receptor Positive Advanced Breast Cancer

**calgb 40502**: A Randomized Phase III Trial of Weekly Paclitaxel Compared to Weekly Nanoparticle Albumin Bound Nab-Paclitaxel or Ixabepilone Combined with Bevacizumab as First-Line Therapy for Locally Recurrent or Metastatic Breast Cancer

**calgb 40503**: Endocrine Therapy in Combination with Anti-VEGF Therapy: A Randomized, Double-Blind, Placebo-Controlled Phase IIII Trial of Endocrine Therapy Alone or Endocrine Therapy Plus Bevacizumab (nsc 704865); IND 7921) For Women With Hormone Receptor-Positive Advanced Breast Cancer

**swog 0622**: Phase II Studies of Two Different Schedules of Dasatinib (nsc-732517) in Bone-Metastasis Predominant Metastatic Breast Cancer

**ctsu e1105**: A Randomized Phase IIII Double-Blind Placebo-Controlled Trial of First-line Chemotherapy and Trastuzumab with or without Bevacizumab for Patients with HER-2/NEU Over-expressing Metastatic Breast Cancer

**lung cancer — non small cell**

**calgb 30605**: A Phase II Study of Induction Chemotherapy Followed by Thoracic Radiotherapy and Erlotinib in Poor-Risk Stage IIII Non-Small Cell Lung Cancer

**calgb 30607**: Randomized, Phase IIII, Placebo-Controlled Trial of Sunitinib as Maintenance Therapy in Non-Progressing Patients Following an Initial Four Cycles of Platinum-Based Combination Chemotherapy in Advanced, Stage IIIIb/IV Non-Small Cell Lung Cancer

**calgb 30704**: A Randomized Phase II Study to Assess the Efficacy of Pemetrexed or Sunitinib or Pemetrexed Plus Sunitinib in the Second-Line Treatment of Advanced Non-Small Cell Lung Cancer
**LUNG CANCER**

- **CALGB 30610**: A Phase III Comparison of Thoracic Radiotherapy Regimens in Patients with Limited Small Cell Lung Cancer (Mostly Receiving Cisplatin and Etoposide)

**GI CANCER—COLO-RECTAL**

- **CALGB 80405**: A Phase III Trial of Irinotecan/5-FU/Leucovorin or Oxaliplatin/5-FU/Leucovorin with Bevacizumab, or Cetuximab (C225), or with the Combination of Bevacizumab and Cetuximab for Patients with Untreated Metastatic Adenocarcinoma of the Colon or Rectum

**CTSU E1505**: A Phase III Randomized Trial of Adjuvant Chemotherapy With or Without Bevacizumab for Patients With Completely Resected Stage IB-IIIA Non-Small Cell Lung Cancer (NSCLC)

**SWOG 0819**: A Randomized, Phase III Study Comparing Carboplatin/Paclitaxel or Carboplatin/Paclitaxel/Bevacizumab with or without Concurrent Cetuximab in Patients with Advanced Non-Small Cell Lung Cancer (NSCLC)

**CALGB 70501**: Collection of Patient-Reported Symptoms and Performance Status via the Internet

**CALGB 0400**: A Clinical Trial Comparing Preoperative Radiation Therapy and Capecitabine with or without Oxaliplatin with Preoperative Radiation Therapy and Continuous Intravenous Infusion of 5-Fluorouracil with or without Oxaliplatin in the Treatment of Patients with Operable Carcinoma of the Rectum

**NSAPB R-04**: A Clinical Trial Comparing Preoperative Radiation Therapy and Capecitabine with or without Oxaliplatin with Preoperative Radiation Therapy and Continuous Intravenous Infusion of 5-Fluorouracil with or without Oxaliplatin in the Treatment of Patients with Operable Carcinoma of the Rectum

**CTSU E2805**: **ASSURE** Adjuvant Sorafenib or Sunitinib for Unfavorable Renal Carcinoma

**MELANOMA**

- **SWOG 0826**: A Phase II Trial of SCH-727965 (NSC-747135) in Patients with Stage IV Melanoma

**GU CANCER**

- **SWOG 0421**: A Phase III Study of Docetaxel and Atrasentan Versus Docetaxel and Placebo for Patients with Advanced Hormone Refractory Prostate Cancer

**GU CANCER—RENAI**

- **CTSU E2804**: The **BEST** Trial: A Randomized Phase II Study of VEGF, RAF Kinase and mTOR Combination Targeted Therapy with Bevacizumab, Sorafenib and Temsirolimus in Advanced Renal Cell Carcinoma

**HEAD & NECK**

- **CTSU E1305**: A Phase III Randomized Trial of Chemotherapy With or Without Bevacizumab in Patients with Recurrent or Metastatic Head and Neck

**CANCER CONTROL/SYMPOTM MANAGEMENT**

- **CALGB 170601**: Phase III Double Blind Trial of Oral Duloxetine for Treatment of Pain Associated with Chemotherapy-Induced Peripheral Neuropathy (CIPN)

- **HLMCC 0501**: Stress Management Therapy for Patients Undergoing Chemotherapy
Contra Costa Regional Medical Center is part of Contra Costa Health Services, an integrated county health system whose mission is to care for and improve the health of all people in Contra Costa County with special attention to those who are most vulnerable to health problems.