BUILDING On STRENGTH
2013 ANNUAL REPORT

MULTIDISCIPLINARY CLINICAL TEAMS + PATIENT NAVIGATION
+ GENETIC COUNSELING + CLINICAL RESEARCH + CLINICAL EDUCATION + INTEGRATIVE MEDICINE + PATIENT SUPPORT AND EDUCATION + INNOVATIVE CLINICAL TRIALS CENTER
+ SURVIVOR CELEBRATIONS + COMMUNITY OUTREACH
Baylor Dallas Leadership: Building on Strength

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Baylor Charles A. Sammons Cancer Center at Dallas

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Over the past several years, our annual reports have concentrated on building. We have built physical facilities including the Baylor Charles A. Sammons Cancer Center at Dallas which opened in March 2011, and in 2012, the Baylor T. Boone Pickens Cancer Hospital. In addition to our advanced facilities, we continue to build with hope through innovative treatment opportunities and outstanding patient support.

In 2013, we continued to build, but not as much with bricks and mortar, but building on our strengths. The Blood and Marrow Transplant Program celebrated 30 years of providing curative treatment opportunities and performed the 5000th transplant since the program’s inception. Clinical trials opportunities increased with the opening in September of the Swim Across America Innovative Clinical Trials Center. With the generous support of the Swim Across America organization, we can now offer more patients the opportunity to participate in clinical trials of advanced investigational therapies including targeted and immunotherapies.

Site-Tumor conferences, a mainstay of our academic approach to multidisciplinary treatment planning, have expanded and new conferences centered around pancreatic and colorectal cancer were added. Scientific publications in peer-reviewed journals continued to rise and have doubled in the past five years.

There has been growth in the cancer genetics program with expansion of the genetics counseling program with additional counselors, more cancers covered and expansion to other Baylor facilities. In addition, our stellar patient navigation program continues to serve more patients every year.

Throughout the following pages you will read of how the Baylor Charles A. Sammons Cancer Center at Dallas is building on these and other strengths to provide more options and hope to those with cancer.

Alan M. Miller, MD, PhD
Chief of Oncology, Baylor Health Care System
Medical Director, Baylor Charles A. Sammons Cancer Center at Dallas

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“BUILDING ON STRENGTH” Baylor Charles A. Sammons Cancer Center at Dallas

CANCER COMMITTEE MEMBERS

Required Members:
John T. Prevedlt, Sr, MD, Chair (Surgery)
(Cancer Registry Quality Coordinator)
Erik Obevian, MD (Radiology)
E. Scott Creek, MD (Radiation Oncology)
Peter A. Dyart, MD (Pathology)
Robert L. Fine, MD (Palliative Care)
E. Colm Koen, MD, PhD (Cancer Liaison Physician)
Curtain M. Matthews, MD (Quality Improvement Coordinator)
Robert G. Mennel, MD (Medical Oncology)
Amy J. Wilson, MD (Hematology)
Johanna Bannock, RN, CPHQ (Performance Improvement/Quality Management)
Pan Cerameas, MHA (Quality Center)
Community Outreach Coordinator
Sylva Coats (Cancer Program Administrator)
Michelle Murray, PhD (Psychosocial Services Coordinator)
Janet Reynolds, CTR (CTE) (Cancer Conference Coordinator)
Cheryl Sampson, CCP, MBA (Clinical Research Coordinator)
Kathleen Shuy, RN, AONN, BSN (Oncology Nurse)
Shery Walker, MSG (Social Work)
Kathy Thomas Welch, LMSW (Social Work)

Other Members:
Carla Borne, MD
Vonne Cook, MD
Karen L. Frick, MD
James W. Freshman, MD
Jatineh Jones, RN, FACHE
Ronald C., Jones, MD
Kariit Kondrat, MD
Z. H. Lahlom, MD
Alan A. Miller, MD, PhD
John C. OBrien, MD
John E. Pippen, Jr., MD, FACP
Charles T. Richardson, MD
Rachalle Valera, MD
Estil A. Vance, II, MD
David L. Welke, MD

W. Scott Webster, MD
Bary T. Wilcox, MD
Lath Ablanvin, MD (House Staff Representative)
Sarah Sellardt McFadden, MD
(Home Staff Representative)
Leah Zehnder, MD (House Staff Representative)

Invited to Attend:
Patrick Allgood, RN, BSN
Anna Garber
Jane Darracker, RN, MBA
Ann Goddess, ACS
Kimberly Hanna, RN, BSN, OCN, CPNP
John McWorter, President/CEO
Noah Igoe, PharmD
Lynn Randolph, VP Nursing
Taryn Pemberton, Marketing
Laura Siciliano, RN, CTR
Julie Smith, Marketing
Baylor Charles A. Sammons Cancer Center at Dallas offers treatment for all forms of cancer, with particular emphasis on lung, pancreas, colon, breast, prostate, and gynecologic cancers.

Physicians on the medical staff of Baylor Sammons Cancer Center at Dallas also have special expertise in treating blood and bone marrow cancers such as leukemia, lymphoma and myeloma.

Baylor offers a full spectrum of oncology services, from education to advanced treatment options and rehabilitation programs.

Specialists and staff work diligently to treat patients in an environment filled with compassionate, quality care by using effective methods in prevention, diagnostic, and treatment.

Depending on the type of cancer and the needs of each individual patient, both standard and innovative treatment options are available. Therapies include blood and marrow transplantation, surgery, chemotherapy, immunotherapy, radiation, CyberKnife® and Gamma Knife® radiosurgery, monoclonal antibodies, thermal ablation for liver cancer, and ultrasound-guided transperineal radioactive seed implants. Scientists at Baylor Sammons Cancer Center perform extensive cancer research, and support services like the Cvietko Patient Education Center, Ernie’s Appearance Center, and the Healing Environment Program help Baylor Sammons Cancer Center treat the whole patient.

For nearly four decades, Baylor Charles A. Sammons Cancer Center has provided quality clinical care, advanced technology, and clinical research to patients, along with comprehensive support services and programs for patients and their families.

With the opening of the 10-story outpatient treatment facility and integration with Baylor T. Boone Pickens Cancer Hospital in Dallas, it is now the largest outpatient cancer center in North Texas. Annually, more than 90,000 cancer visits occur at Baylor Sammons Cancer Center at Dallas, and more than 800 people participate in research trials.

Baylor Charles A. Sammons Cancer Center Network

Seven facilities across Baylor Health Care System carry the Baylor Charles A. Sammons Cancer Center name as part of the system’s focus to bring patients throughout North Texas quality clinical care and advanced technology. Facilities in McKinney and Carrollton also offer oncology services and are expected to carry the Baylor Charles A. Sammons Cancer Center name in the future.

Baylor T. Boone Pickens Cancer Hospital

This is the first dedicated cancer hospital in North Texas and only the second in the state. This 96-bed, 175,000-square-foot facility has been specially designed to provide a place of healing, calming, and spirituality. A skybridge connects the inpatient hospital to the many outpatient services of Baylor Sammons Cancer Center at Dallas. Larger rooms enable patient families and caregivers to have their own space, and families and caregivers have access to two areas in the hospital for showering, washing clothes, working or relaxing.
Celebrating more than 30 years and 5,000 transplants, the Blood and Marrow Transplant (BMT) Program at Baylor Charles A. Sammons Cancer Center at Dallas, is one of the leading blood and marrow programs in the state of Texas, and has grown into one of the largest and most comprehensive in the nation. Led by Edward Agura, MD, medical director, our BMT program continues to move research forward to improve outcomes for those affected by blood cancers and deficiencies for which bone marrow transplantation may provide lifesaving treatment. “If a patient comes to us today for a bone marrow transplant, there is almost no reason we cannot find a donor for him or her,” says Dr. Agura.

At Baylor University Medical Center at Dallas, the BMT team is performing a study comparing the use of umbilical cord blood versus conventional marrow or peripheral blood stem cell transplants. The stem cells in cord blood have a rare capacity to repair bone marrow and boost immune system recovery. “The patient’s diseased bone marrow with cancer is completely eliminated with high doses of chemotherapy and sometimes radiation, or a combination of the two,” says Luis Pinoano, MD, FACF, a hematologic oncologist on the medical staff at Baylor Dallas. “Healthy stem cells from a donor will repopulate the bone marrow. In the case of inherited deficiencies, the ‘deficient’ cells will be replenished by the healthy transplanted donor cells.”

Healing Power
About 70 percent of individuals requiring a stem cell transplant are not able to find a suitable match in their family. Through the BMT program’s research efforts, patients have access to donated cord blood units that have been frozen and stored for transplantation. “Not long ago, cord blood was discarded,” says Dr. Pinoano. “It is incredible that today it can be utilized to perform life-saving procedures.”

Unlike adult hematopoietic—or blood-forming—stem cells, cord blood stem cells are young, flexible cells that can easily develop into different blood cell types that perform specialized tasks. For people with blood cancers such as leukemia, lymphoma and myeloma, an infusion of cord blood stem cells can regenerate bone marrow following cancer therapy. For individuals with inherited disorders of red blood cell production, such as sickle cell anemia or thalassemia, cord blood stem cells can replace defective cells with a genetically normal counterpart, thus restoring red-cell function: the delivery of vital oxygen to the body. In immune deficiency disease, cord blood stem cells help fend off infections and diseases by replacing defective white blood cells with their healthy counterparts.
Flexible Fit

For a transplant to be successful, the human leukocyte antigen (HLA) markers in the donor’s stem cells must match those of the recipient. Because cord blood stem cells are better able to adapt themselves to a patient’s body, there is less chance of immunologic side effects such as rejection or graft-versus-host disease.

“When used for transplantation these cells are more tolerant, and therefore less likely to get ‘activated’ when exposed to their new environment in the recipient. The end result is less rejection and less graft-versus-host reaction,” says Dr. Pineiro. “Since we expect to see less immunologic activation, we can then use ‘less than perfect’ matches for transplantation. This has increased the number of patients in which stem cell transplant is feasible.”

Although cord blood contains fewer stem cells than a marrow or blood stem cell transplant, Baylor researchers are able to combine cord blood products from multiple donors, thereby increasing the number of stem cells infused and providing faster recovery of blood counts.

**BLOOD AND MARROW TRANSPLANT PROGRAM:**
**CURATIVE CELL RESEARCH**
Recognizing the critical importance of phase 1 trials, Baylor Charles A. Sammons Cancer Center at Dallas boasts a 6,375-square-foot facility, the Swim Across America Innovative Clinical Trials Center (ICTC), offering patients better access to a wide range of new research and treatment options. The ICTC expands the already extensive program of cancer clinical trials offered at Baylor Sammons Cancer Center.

With the cost of bringing a new drug to market currently hovering around $1 billion, or more, phase 1 clinical trials at the ICTC continue, in part, due to funding sponsors from pharmaceutical or biotechnology companies; however, for those agents without a sponsor, other funding must be found to run the clinical trials. An ideal match was found for the ICTC when Swim Across America (SAA), a national organization that holds swim-related events to raise funds supporting cancer research, prevention and treatment, came forward with an offer to support the center. According to Daniel Watters, chairman of the SAA-Dallas committee and a member of the 1988 U.S. Olympic swim team, SAA-Dallas chose to support the ICTC at Baylor Sammons Cancer Center at Dallas after an intensive search for “the best of the best” in terms of cancer research and treatment in North Texas.

The first open-water swim, held in June 2011 at Lake Ray Hubbard in Rockwall, Texas, was the beginning of a four-year commitment to the ICTC, with the goal of raising in excess of $1 million during those four years to benefit the phase 1 clinical trials program. SAA-Dallas is likely to exceed that goal with its third swim in June 2013 bringing the total amount raised to $950,000. “We hope and anticipate that this commitment will be extended for many, many more years to come,” says Watters.

In recognition of the support and dedication of SAA-Dallas, the ICTC has been named the Swim Across America Innovative Clinical Trials Center at Baylor Charles A. Sammons Cancer Center at Dallas. The naming was officially announced on June 7, 2013, the day before the open-water swim.

Under the leadership of Carlos Bacerra, MD, medical director of the ICTC, the center plans to use the expanding knowledge about the biology and genetics of cancer in exploring novel treatments for patients with hard-to-treat cancers. Says Dr. Bacerra, “In the past, for breast cancer or colon cancer, as examples, we treated everyone the same. Now, as we dissect tumors at the molecular genetic level, we have learned that colon or breast cancer can be subdissected into different types of disease that need to be treated differently. This gives us the knowledge to be smarter in treating our patients, using specific drugs to shut down specific pathways.”

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Because of current genetic research, physicians now have the tools to identify specific genetic mutations passed down through families that are responsible for a large number of colon cancers. “The current estimate is that one in 200 people has one of these genetic mutations,” says C. Richard Boland, MD, chief of gastrointestinalology and a physician on the medical staff at Baylor University Medical Center at Dallas. The condition is called Lynch syndrome, and knowing its genetic roots gives people the chance to protect themselves and their families from the cancers it can cause.

Experts estimate that three out of every 100 colon cancers are caused by Lynch syndrome. Screening is critical because colorectal cancer is the third most common cancer – about 150,000 Americans are diagnosed annually. It’s also the third most deadly, claiming about 50,000 lives each year, according to the American Cancer Society.

When Dr. Boland first theorized that inherited genes were the cause, he did not have to go far to find a family to study. “My father first got colon cancer when he was in his mid-20s,” he says. “Ten out of 13 of his siblings had cancer of some kind. So for me, this is personal.” Though few others supported Dr. Boland’s theory about a genetic link, Henry T. Lynch, MD, had published papers to support just that. In one of his own papers, Dr. Boland named the connection “Lynch syndrome.” Today, researchers have not only confirmed that Lynch syndrome is surprisingly common, but they’ve identified how the mutations lead to cancer. Research also shows that, among people with Lynch syndrome, the chance of having colorectal cancer is 70 percent in men and 40 percent in women. Women also have a 40 percent chance of having endometrial cancers (in the lining of the uterus), plus smaller risks of having a variety of other cancers. Also, a child of someone with the condition has a 30 percent chance of having it, a fact that leads to large clusters of affected relatives, as in Dr. Boland’s family. “Once we identify one person with it, we end up working with entire families,” Dr. Boland says. “Then, we are able to alter how Lynch affects a person and their relatives.”

Genetic counseling at Baylor Charles A. Sammons Cancer Center at Dallas can help identify patients who are at risk of developing colon cancer as a result of a genetic mutation. Board-certified genetic counselors help patients understand their diagnosis, the inheritance pattern, and the recommended screening and prevention options.
Getting an annual mammogram is important, but life sometimes gets in the way of keeping that potentially lifesaving appointment. “Women often don’t take the time to take care of their health like they should,” says Sherry Fox, mobile account executive at Baylor University Medical Center at Dallas. “By making mammograms convenient and efficient though, they’re much more likely to follow through.” Baylor Dallas’ Darlene G. Casa Women’s Imaging Center Mobile Mammography aims to do just that. The 41-foot coach is staffed by two women, including a certified mammographer, and travels to businesses, churches, school districts and corporations to bring mammography services to women right where they are.

The specially-designed bus equipped with three-dimensional breast imaging technology began making regular stops at key locations in the fall of 2013. The mobile machine enables women to have quality breast screening at a location convenient for them. The bus serves patients with two changing rooms with direct access to the mammography area assuring convenience and privacy. The mobile program can serve up to 50 women per day and the vehicle is equipped with internet capabilities to sync patient data with the hospital.

“The mobile program features digital mammography that includes Computer Assisted Detection (CAD), an application that scans the patient’s screening mammogram to identify suspicious features that may warrant a second review by the radiologist,” says Ethel Randall, director of breast imaging for Baylor Health Care System’s Baylor Charles A. Sammons Cancer Center. “Digital mammography technology also provides faster processing times and the ability to store images electronically.
COMMUNITY EVENTS/OUTREACH: TAKING CANCER INFORMATION AND SCREENING TO THE COMMUNITY

American Cancer Society
The American Cancer Society has been an incredible supporter of Baylor Sammons Cancer Center at Dallas to deliver lifesaving results. Together, we are a relentless force fighting cancer. American Cancer Society representatives collaborate with oncology staff to deliver support, and serve on the cancer committee to help provide resources to fulfill the Commission on Cancer standards for cancer care.

In 2013, the American Cancer Society served 1,026 patients with 3,148 services at Baylor University Medical Center at Dallas. Patients received weekly support from the Society’s ACS Day representative and all newly diagnosed patients received a Personal Health Manager kit from the Society which provides personalized information on their specific cancer type, as well as helping patients and caregivers keep appointments, test results and prescriptions organized throughout treatment. As the official sponsor of birthdays, the American Cancer Society knows how important each and every birthday can be. In May of 2013, the Society celebrated its 100th birthday – one hundred years of saving lives and twenty years supporting Baylor hospitals. In the last two decades the Society has contributed to a 20% decline in cancer death rates in the US. Last year the Society and Baylor hospitals reached over 2,100 patients with more than 6,000 programs and services, that’s 1-in-4 cancer patients treated at Baylor receiving valuable services by the Society.

Patients at Baylor University Medical Center at Dallas are able to receive guidance on Society programs, including the Reach To Recovery® program for those coping with their breast cancer experience. Female patients may also get involved in the Look Good Feel Better® program, dedicated to improving the self-esteem and quality of life of people undergoing treatment. Through the Patient Navigation Program, patient navigation provide free and confidential support and guidance to all patients and their caregivers during their cancer journey.

The American Cancer Society is the only organization offering cancer patients and their families around-the-clock guidance and support through their toll-free line, 1-800-227-2345 and at www.cancer.org.

Cancer education and support are two vital components in one’s cancer journey. Baylor Charles A. Sammons Cancer Center boasts a beautiful patient education and support center named in honor of one of our former patients, Virginia R. Cvetko. The Cvetko Center provides many disease-specific education and support programs to help patients and their caregivers understand the physical, emotional and spiritual challenges of fighting cancer.

Disease-Specific Support Groups
• Amyloid Support North Texas: Quarterly
• Bladder/Kidney Cancer Support Group: Monthly
• Breast Cancer Support Group: Monthly
• Gastrointestinal Cancer Support Group: Every other Monday
• Lung Cancer Education Support Group: Monthly
• North Texas Myeloma Support Group: Monthly
• Ovarian Cancer Support Group: Every other Monday
• Information on Neck Cancer Support Group: Monthly
• Prostate Cancer Education and Support Group: Monthly
• Waldenstrom’s Macroglobulinemia Support Group: Bimonthly
• Young Adult Cancer Survivors: Bimonthly

Together, we are a relentless force fighting cancer.
Free Community Screenings
Baylor Sammons Cancer Center at Dallas hosted a head and neck cancer screening on April 27 followed by a skin cancer screening conducted on May 11. In all, a total of 38 patients received abnormal results and were contacted by a member of our patient navigation team to facilitate an appointment with a member of our medical staff.

Community Outreach Events
On October 6, women from throughout Dallas gathered to take a proactive stand against breast and ovarian cancers at this year’s Sole Sisters™ event held at Tower Club Dallas. This health & beauty boot camp event promotes good health/fitness practices and early detection. More than 100 women enjoyed spa treatments, group workout classes and health/beauty consultations. More than 100 women enjoyed spa treatments, group workout classes and health/beauty consultations. A special highlight of the event was an interactive discussion panel covering genetics, prevention/screening, integrative medicine and survivorship. Ivana Hall, Miss Texas 2013 served as event emcee.

More than 100 survivors and their families attended the Blood and Marrow Transplant Reunion: Cirque du Celebr-ation, on September 29, 2013. Attendees enjoyed carnival style games, treats and were entertained by Circus Freaks, a circus style performance group. The highlight of the reunion was when John King, a leukemia survivor from Bossier City, Louisiana met his blood donor match, Camilla Bresciani who traveled from Dubai to meet the man her donation saved. Through the Be The Match® National Marrow Donor Program database, Camilla was identified as a perfect match for Mr. King, enabling him to receive his life-saving transplant on June 5, 2012.

Baylor Charles A. Sammons Cancer Center at Dallas hosted a lighted vigil as part of a national campaign to raise awareness for lung cancer on November 14, 2013. Dallas joined more than 100 communities across the nation in hosting a Shine a Light on Lung Cancer Vigil in collaboration with the Lung Cancer Alliance. The purpose of this vigil was designed to provide hope, support and compassion to the thousands who are diagnosed with lung cancer.

Young Adult Cancer Survivors’ Summit
In an effort to better meet the needs of young adult cancer survivors (YACS), the Young Adult Cancer Survivors’ Coalition hosted the annual Down with Cancer, Up with Survival YACS Summit in April at the University of Texas at Arlington.

This year’s event featured keynote speakers Heidi Adams, a young adult cancer survivor, author and president and CEO of Critical Misses along with Karen Albritton, MD, a researcher specializing in young adult cancers at Cook Children’s Medical Center at Fort Worth. Event attendees participated in interactive breakout sessions covering topics such as nutrition, caregiving and building emotional support.
Baylor Samuel Cancer Center at Dallas held 350 site-specific tumor conferences in 2013, where more than 1,500 patients were discussed. Nearly 8,000 physicians, trainees, nurses and allied health staff attended these conferences focusing on malignancies in bone and soft tissue, breast, chest, colorectal, endocrine, GI, gynecology, head and neck, liver, neuro-oncology, pancreas, skin, urology and hematopoietic diseases.

Value of Tumor Conferences by Robert G. Mennel, MD

The value of the tumor conferences can be summed up in four benefits:

1. Exposure to interesting and problematic cases:
   - The conferences are a clearing-house for the most interesting and difficult cases seen at Baylor. In this one place a health care professional can learn about every aspect of a patient’s case, the pathology, the radiological findings, the genetics, the social impediments to the therapy, etc.
   - The whole book of business about the patient’s problem is presented in one venue. It has tremendous value and efficiency of time for the health care practitioner.

2. Insight into other disciplines’ thought processes towards the same problem:
   - Different disciplines, by virtue of their training, approach the same problem from different angles. For example, the pathologist and medical oncologist may need more tissue for a diagnosis and think that this would be a minor procedure of very little risk for the patient. However, the interventional radiologist or surgeon sitting in the same room and looking at the same images may point out that the procedure to get the tissue may be much more involved than originally thought and fraught with significant risk for the patient. This could change the whole care of the patient.

3. Education leading ultimately to better patient care:
   - These conferences have all levels of trainees from students to staff and all disciplines from general surgeons to genetic counselors. Interpreting X-rays with a radiologist teaches the other disciplines how to interpret X-rays, what is the best X-ray to order, and the problems the radiologist faces in interpreting the film. The same is true for anatomic pathologists, molecular pathologists, surgeons, medical oncologists, and radiation oncologists. Having the scientific studies presented that apply to this patient’s disease teaches everyone about the disease. Education and discussion lead to better patient care.

4. Professional camaraderie:
   - In this era of increasing ways of communication (emails, tweets, webinars, etc.) but decreasing depth of communication, these conferences put everyone in the same room, face to face, to engage in education and friendly professional bantering that builds the ties within this cancer center. This camaraderie may be the major benefit of our tumor conferences.
Clinical Oncology Research Coordination (CORC) Office

The Clinical Oncology Research Coordination Office underwent a major change in April of 2013 when Angelia Drake, MSN, RN, assumed the role of director. In addition to being responsible for this system-wide office she also supervises the Division of Surgical Oncology and the development of the Surgical Oncology Clinical Research Database or SOCRRD. SOCRRD is a meta-registry where multiple databases are connected from the tumor registry data imports, multi-disciplinary tumor conferences, investigator-initiated clinical trials, pathology, and radiology.

SOCRRD is a central location where information from all of these sources can be stored, validated, and accessed for feasibility and future research. Currently, Drake and her staff are re-vamping the infrastructure and processes in the department to accommodate the rapid expansion of clinical trials in Baylor Health Care System. While focusing on continuing the growth of these trials, as well as trials in the Innovative Clinical Trials Center (ICTC), the department is maintaining its focus on providing quality and service to patients, investigators, and sponsors. In August 2013, M.Y. Levy, MD, became the medical director of Hematological Malignancies of the ICTC. Thanks to Dr. Levy and Dr. Carlos Becerra, medical director of Hematological Malignancies, there has been a big increase in the number of phase I and II trials being offered through the clinic. At present, oncology clinical trials are being conducted at the Dallas, Fort Worth, and Irving campuses. CORC hopes to expand to more of the Baylor Health Care System hospitals in the near future. The expanded network of locations for clinical trials should result in growth of the number of clinical trials and the number of patients enrolled in the trials.

At Baylor Charles A. Sammons Cancer Center at Dallas, we understand the overwhelming nature of a cancer diagnosis. Understanding and following complex treatment recommendations can be difficult for both the cancer patient and family members. This is why every family that walks through our doors has access to a patient navigator. Our patient navigation team is a group of dedicated registered nurses that partner with patients and their families to serve as an advocate, guide, and resource through cancer treatment and recovery. Our patient navigation team also works very closely with our Virginia R. Cvetko Patient Education and Support Center. Free cancer screenings are one of many resources our Cvetko Center offers to the community. In 2013, we screened 109 individuals and found 38 of them to be at risk for either skin cancer or head and neck cancer. To make sure those at-risk individuals are connected with a physician on staff at Baylor as quickly as possible, patient navigators will call each person to facilitate setting up an appointment with the appropriate provider.

PATIENT NAVIGATION:
- **Answer Questions and Address Patient Concerns**
- **Educate and Empower Patients to Make an Informed Decision**
- **Work with a Multidisciplinary Team of Doctors to Provide Efficient, Timely, and Quality Care**
- **Assist Patient and Family Members with Finding Appropriate Resources**
- **Explore and Assist with Financial Resources**
TERI RODGERS: MELANOMA – IMMUNOTHERAPY – INTERLEUKIN II

In 2009, Rodgers’ scans revealed another tumor. She began a two-year clinical trial testing another form of immunotherapy at Baylor Charles A. Sammons Cancer Center at Dallas. Today, she has been cancer free for two years. Rodgers credits her physicians and the clinical trials offered through Baylor Institute for Immunology Research for her remarkable recovery.

Rodgers has taken a new position as a school counselor in a smaller school district. She enjoys every day with her husband and children and she says every day she remembers her for she and her family have come and friends over to her home. “I love the feel and sound of a house full of friends and family and the memories that are made,” she says.

“In addition to working full time, Rodgers enjoys traveling, spending time with her family, gardening, cooking and having friends over to her home. “I love the feel and sound of a house full of friends and family and the memories that are made,” she says.”

"I’ve always had a servant’s heart and a willingness to help others, but now I have a real life battle and I’m committed to being a living testimony to share with others and help them fight for what they want or aspire to become. Fortunately, there’s a lot of grief and struggle in our world, yet I get to share my success story and hopefully encourage others along their journey. The gift of life is precious and I don’t ever want to take it for granted. I’ve lost several friends along this journey and I know that I am here for a reason. I don’t ever want to miss out on an opportunity God has put me here for.”

“I’m living proof that immunotherapy works and that there can be hope and a light at the end of the tunnel.”

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**Estimated Number** of New Cancer Cases by Sex, US, 2013 vs. State of Texas, 2013 vs. **Actual Number** of Analytic Cancer Cases by Sex, Baylor Health Care System, 2012

### Top Ten Cancer Sites

#### Men

<table>
<thead>
<tr>
<th>Site</th>
<th>Estimated New Cancer Cases Nationally, 2013</th>
<th>Estimated New Cancer Cases in the State of Texas, 2013</th>
<th>Actual Cancer Cases, Baylor University Medical Center, 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate</td>
<td>238,590</td>
<td>137,370</td>
<td>173** 13%</td>
</tr>
<tr>
<td>Lung &amp; Bronchus</td>
<td>118,080</td>
<td>9,054</td>
<td>109** 9%</td>
</tr>
<tr>
<td>Colon &amp; Rectum</td>
<td>73,680</td>
<td>6,058</td>
<td>136 11%</td>
</tr>
<tr>
<td>Uterine Bladder</td>
<td>54,610</td>
<td>3,081</td>
<td>49 4%</td>
</tr>
<tr>
<td>Melanoma of the Skin</td>
<td>45,060</td>
<td>2,989</td>
<td>47 4%</td>
</tr>
<tr>
<td>Kidney &amp; Renal Pelvis</td>
<td>40,430</td>
<td>2,734</td>
<td>75 6%</td>
</tr>
<tr>
<td>Non-Hodgkin Lymphoma</td>
<td>37,630</td>
<td>2,540</td>
<td>56 9%</td>
</tr>
<tr>
<td>Oral Cavity &amp; Pharynx</td>
<td>29,620</td>
<td>1,943</td>
<td>52 4%</td>
</tr>
<tr>
<td>Leukemia</td>
<td>27,880</td>
<td>1,870</td>
<td>47 4%</td>
</tr>
<tr>
<td>Pancreas</td>
<td>22,740</td>
<td>1,449</td>
<td>41 3%</td>
</tr>
<tr>
<td>All Sites</td>
<td>854,790</td>
<td>62,740</td>
<td>1212 100%</td>
</tr>
</tbody>
</table>

#### Women

<table>
<thead>
<tr>
<th>Site</th>
<th>Estimated New Cancer Cases Nationally, 2013</th>
<th>Estimated New Cancer Cases in the State of Texas, 2013</th>
<th>Actual Cancer Cases, Baylor University Medical Center, 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>252,340</td>
<td>17,652</td>
<td>580 27%</td>
</tr>
<tr>
<td>Lung &amp; Bronchus</td>
<td>110,110</td>
<td>6,570</td>
<td>102 6%</td>
</tr>
<tr>
<td>Colon &amp; Rectum</td>
<td>69,140</td>
<td>4,975</td>
<td>95 6%</td>
</tr>
<tr>
<td>Uterine Corpus</td>
<td>49,960</td>
<td>2,863</td>
<td>127 8%</td>
</tr>
<tr>
<td>Thyroid</td>
<td>45,310</td>
<td>2,076</td>
<td>71 4%</td>
</tr>
<tr>
<td>Non-Hodgkin Lymphoma</td>
<td>32,310</td>
<td>2,111</td>
<td>37 2%</td>
</tr>
<tr>
<td>Melanoma of the Skin</td>
<td>31,630</td>
<td>1,978</td>
<td>43 6%</td>
</tr>
<tr>
<td>Kidney &amp; Renal Pelvis</td>
<td>24,720</td>
<td>1,773</td>
<td>39 2%</td>
</tr>
<tr>
<td>Pancreas</td>
<td>22,480</td>
<td>1,325</td>
<td>47 3%</td>
</tr>
<tr>
<td>Ovary</td>
<td>22,340</td>
<td>1,628</td>
<td>40 3%</td>
</tr>
<tr>
<td>All Sites</td>
<td>803,030</td>
<td>54,632</td>
<td>1,580 100%</td>
</tr>
</tbody>
</table>

**Source:** American Cancer Society, Inc., Surveillance Research

*2013, American Cancer Society, Inc., Surveillance Research

**Cancer Epidemiology and Surveillance Branch, Texas Department of State Health Services, April 2013

**Baylor Health Care System Cancer Registry, Electronic Registry System**
## Oncology Quality Metrics 2012

### Breast Cancer

<table>
<thead>
<tr>
<th>Metric</th>
<th>NCCN Target</th>
<th>NCDB, CoC, NQF, NAPBC</th>
<th>Baylor University Medical Center Performance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Breast Conserving Surgery Irradiation: Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 and receiving breast-conserving surgery for breast cancer (Accountability Measure)</td>
<td>NCCN, CoC, NQF, NAPBC</td>
<td>90%</td>
<td>90%</td>
</tr>
</tbody>
</table>

### Adjuvant Chemotherapy: Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cNoMo, or Stage II or III hormone receptor negative breast cancer (Accountability Measure) | NCCN, CoC, NQF, NAPBC | 90% | 90% | 0% | 90.5% | 92.5% | 96.6% | 94.3% | 98% |

### Adjuvant Hormonal Therapy: Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1cNoMo, or Stage II or III hormone receptor positive breast cancer (Accountability Measure) | NCCN, CoC, NQF, NAPBC | 90% | 90% | 85.1% | 87.1% | 90.3% | 94.9% | 91.1% | 95.1% |

### Colorectal Cancer

<table>
<thead>
<tr>
<th>Metric</th>
<th>NCCN Target</th>
<th>NCDB, CoC, NQF, NAPBC</th>
<th>Baylor University Medical Center Performance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjuvant Chemotherapy: Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis to patients under age 80 with AJCC III (lymph node positive) colon cancer (Accountability Measure)</td>
<td>NCCN, CoC, NQF</td>
<td>90%</td>
<td>90%</td>
</tr>
</tbody>
</table>

### Surgical Resection Includes at Least 12 Lymph Nodes: At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer (Surveillance Measure) | NCCN, CoC, NQF | 80% | 80% | 90.5% | 89% | 87.8% | 97.4% | 97.2% | 95.9% |

### Rectal Cancer

<table>
<thead>
<tr>
<th>Metric</th>
<th>NCCN Target</th>
<th>NCDB, CoC, NQF</th>
<th>Baylor University Medical Center Performance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Therapy for Rectal Cancer: Radiation therapy is considered or administered within 6 months (180 days) of diagnosis for patients under the age of 80 with clinical or pathological AJCC T4N0M0 or Stage III receiving surgical resection of rectal cancer (Surveillance Measure)</td>
<td>NCCN, CoC, NQF</td>
<td>90%</td>
<td>90%</td>
</tr>
</tbody>
</table>

*Source: American College of Surgeons National Cancer Data Base*
### Baylor University Medical Center at Dallas: Analytic/Non-analytic Cases Diagnosed 2012

<table>
<thead>
<tr>
<th>Primary Site</th>
<th>Total</th>
<th>Analytic</th>
<th>Non-analytic</th>
<th>Male</th>
<th>Female</th>
<th>In Situ</th>
<th>Local</th>
<th>Regional</th>
<th>Distant</th>
<th>NA/Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Sites</td>
<td>4050</td>
<td>3211</td>
<td>839</td>
<td>1010</td>
<td>2240</td>
<td>150</td>
<td>1345</td>
<td>775</td>
<td>795</td>
<td>780</td>
</tr>
<tr>
<td>Oral Cavity</td>
<td>124</td>
<td>83</td>
<td>41</td>
<td>81</td>
<td>43</td>
<td>0</td>
<td>32</td>
<td>62</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td>Lip</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Tongue</td>
<td>51</td>
<td>36</td>
<td>15</td>
<td>33</td>
<td>18</td>
<td>0</td>
<td>1</td>
<td>25</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Oropharynx</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hypopharynx</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>62</td>
<td>42</td>
<td>20</td>
<td>17</td>
<td>11</td>
<td>0</td>
<td>12</td>
<td>30</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Digestive System</td>
<td>796</td>
<td>592</td>
<td>204</td>
<td>298</td>
<td>6</td>
<td>290</td>
<td>322</td>
<td>158</td>
<td>130</td>
<td>128</td>
</tr>
<tr>
<td>Esophagus</td>
<td>31</td>
<td>21</td>
<td>10</td>
<td>29</td>
<td>2</td>
<td>1</td>
<td>8</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Stomach</td>
<td>43</td>
<td>30</td>
<td>13</td>
<td>17</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>17</td>
<td>12</td>
<td>11</td>
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<tr>
<td>Colon</td>
<td>174</td>
<td>113</td>
<td>61</td>
<td>97</td>
<td>7</td>
<td>0</td>
<td>38</td>
<td>61</td>
<td>45</td>
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<tr>
<td>Pancrust</td>
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<td>110</td>
<td>26</td>
<td>89</td>
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<td>2</td>
<td>44</td>
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</tr>
<tr>
<td>Anus/Anal Canal</td>
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<td>4</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>5</td>
<td>1</td>
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<tr>
<td>Liver</td>
<td>217</td>
<td>178</td>
<td>43</td>
<td>107</td>
<td>54</td>
<td>0</td>
<td>138</td>
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<tr>
<td>Pancreas</td>
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<td>88</td>
<td>39</td>
<td>58</td>
<td>69</td>
<td>2</td>
<td>22</td>
<td>37</td>
<td>46</td>
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<tr>
<td>Respiratory System</td>
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<td>133</td>
<td>216</td>
<td>180</td>
<td>2</td>
<td>62</td>
<td>71</td>
<td>163</td>
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<tr>
<td>Nose/Sinus</td>
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<td>0</td>
<td>1</td>
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<tr>
<td>Larynx</td>
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<tr>
<td>Lung/bronchus</td>
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<td>133</td>
<td>175</td>
<td>177</td>
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<td>62</td>
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<tr>
<td>Blood &amp; Bone Marrow</td>
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<td>123</td>
<td>146</td>
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<td>6</td>
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<td>Connect/Soft Tissue</td>
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<tr>
<td>Skin</td>
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<td>58</td>
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<td>Malignoma</td>
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<td>72</td>
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<td>54</td>
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<td>4</td>
<td>1</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

**Primary Site**

- **Breast**
  - Total: 806
  - Analytic: 555
  - Non-analytic: 211
  - Male: 501
  - Female: 305

**Female Gential**

- Total: 261
- Analytic: 207
- Non-analytic: 54
- Male: 0
- Female: 261

**Corpus Uteri**

- Total: 30
- Analytic: 22
- Non-analytic: 8
- Male: 0
- Female: 22

**Endometriosis**

- Total: 106
- Analytic: 86
- Non-analytic: 20
- Male: 0
- Female: 86

**Lymphatic System**

- Total: 128
- Analytic: 104
- Non-analytic: 24
- Male: 0
- Female: 104

**Urinary System**

- Total: 60
- Analytic: 47
- Non-analytic: 13
- Male: 0
- Female: 47

**Oncology**

- Total: 108
- Analytic: 91
- Non-analytic: 17
- Male: 0
- Female: 91

**Cervix (in-situ)**

- Total: 283
- Analytic: 238
- Non-analytic: 45
- Male: 0
- Female: 238

**Other**

- Total: 10
- Analytic: 6
- Non-analytic: 4
- Male: 0
- Female: 6

Data Source: Electronic Registry System, Baylor Health Care System Cancer Registry.
Background

According to the American Cancer Society, in 2012 there was an estimated 13,780 new cases of acute myelogenous leukemia (AML) and 10,230 deaths. While the 5-year relative survival of patients diagnosed with AML is only 24%, there are large differences in patients’ prognoses, which are influenced by patient-specific factors and perhaps most importantly the genetics of the disease. While AML is initially classified by the French-American-British (FAB) system using cell morphology and cytochemical stains to categorize the disease, a newer classification system developed by the World Health Organization (WHO) that incorporates genetic studies is now used. This system, most recently updated in 2008, combines the traditional clinical features, morphological cytologic criteria with cytogenetic and molecular analyses. Based on the WHO categorization of myeloid neoplasms, AML is defined as the presence of 20% or more blasts in the peripheral blood or bone marrow occurring de novo or in a patient with a prior diagnosis of myeloid leukemia, myelodysplasia, or myeloproliferative neoplasms. In the setting of specific genetic abnormalities, however, the requirement for a blast count of 20% or more does not apply. These specific mutations include t(8;21)(q22;q22), inv(16)(16;16)(15;15), and acute promyelocytic leukemia (APL) with t(15;17)(q22;q12). In addition to the WHO classification system for AML, the International System for Bone Marrow Cells (ISBM) guidelines for reporting genetic alterations in AML were published recently, further delineating AML patients based on genetics as well as age.

Cytogenetic information not only influences the classification of AML but also provides important prognostic information regarding remission rates, risk of relapse, and overall survival. Patients with favorable, intermediate, or adverse cytogenetics have 5-year survival rates of 65%, 41%, and 14%, respectively. Table 1 lists the mutations related to each prognostic group. Classification among risk groups provides important prognostic information regarding response in addition to survival. Those classified as favorable show complete response rates to treatment of 90%, while those in the adverse or unfavorable group have a complete response rate of approximately 60%.

Among patients with normal cytogenetics, or those considered to be at intermediate risk, a more detailed analysis of the presence of molecular markers is needed. Examination of the FLT3, NPM1, CEBPA, RUNX1, MLL, and EVI1 genes allows further risk stratification among the prognostic group, potentially influencing treatment and response treatment. Due to the significant progress that has been made in identifying molecular markers and their role in pathogenesis, new recommendations have been developed that define general practice guidelines for the diagnosis of AML, the most recent published from the International Leukemia

### Table 1. Prognostic Value of Cytogenetic

<table>
<thead>
<tr>
<th>Prognostic Group</th>
<th>5-Year Survival</th>
<th>Mutation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favorable</td>
<td>63%</td>
<td>+t(8;21)(p22;q22)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+t(16;16)(p13.1;q22)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+t(15;15)(q22;p11)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+21</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Normal karyotype with mutated CEPBA, or mutated NPM1 without FLT3</td>
</tr>
<tr>
<td>Intermediate</td>
<td>41%</td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+p13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+p22</td>
</tr>
<tr>
<td></td>
<td></td>
<td>del(16)(p13.1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>+e(16)(p13.1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Abnormal (11q23)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complex cytogenetics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-3</td>
</tr>
</tbody>
</table>

Exception of cytogenetics, though in the case of pure erythroblast leukemias should be considered. In addition to the assessment of blood and bone marrow aspirates, assessment of a bone marrow trephine biopsy may provide valuable information regarding cell maturity, and bone marrow stroma; however, expert panel recommendations consider this evaluation optional, except in the setting of a “dry tap,” where no material is obtained in the biopsy. In addition to morphologic assessment, immunophenotyping using multiparameter flow cytometry or immunohistochemistry is also essential in new AML diagnoses for determination of cell lineage, with a preference towards use of flow cytometry. While consensus data do not give a specific cutoff point for considering a specific marker to be positive, expression of specific markers in >20% of leukemic cells is commonly used.

For all patients with a new or suspected AML diagnosis, cytogenetic analysis is considered mandatory as part of the diagnostic evaluation. Cytogenetic abnormalities are present in approximately 90% of adult AML cases, and they provide the most important prognostic information. Additionally, they allow, in cases of (8;21), (15;15), or (15;16), the AML diagnosis to be made with >30% blasts in the peripheral blood or bone marrow aspirate. As the result of the karyotype are the strongest prognostic factor for predicting response to therapy and overall survival, recommendations suggest that a minimum of 20 morphologically typical cells be analyzed to define an abnormal karyotype, and that this cell number is mandatorily assessed before diagnosing a normal karyotype. For cases with inadequate or failed cytogenetics analyses, fluorescence in situ hybridization (FISH) may be used for detection of gene rearrangements. Based on expert panel recommendations, blood and marrow specimens should be collected routinely for molecular genetic analysis. While conventional cytogenetic studies are considered mandatory, mo-
Table 2. Patient Demographics

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>Total Patients</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favored</td>
<td>21</td>
<td>7</td>
<td>5</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Intermediate</td>
<td>26</td>
<td>8</td>
<td>7</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Adverse</td>
<td>30</td>
<td>9</td>
<td>9</td>
<td>11</td>
<td>11</td>
</tr>
</tbody>
</table>

Table 3. RESULTS

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>HLA Typing</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favored</td>
<td>21</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Intermediate</td>
<td>26</td>
<td>19</td>
<td>7</td>
</tr>
<tr>
<td>Adverse</td>
<td>30</td>
<td>23</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 4. PERFORMANCE of HLA TYPING BY RISK GROUP AND AGE

- **Risk Group:** Favorable, Intermediate, and Adverse
- **Age:** <60 years, 60–69 years, 70–79 years, >80 years

- **HLA Typing:** Yes, No

- **Performance Measures:** Sensitivity, Specificity, Positive Predictive Value, Negative Predictive Value

- **Data Source:** Hospital Records, Laboratory Reports, Clinical Trials

- **Analysis:** Comparative analysis, correlation with clinical outcomes

- **Conclusion:** HLA typing is effective in this patient population, with high accuracy rates and clinical relevance.

- **Limitations:** Limited data on younger age groups, need for larger sample sizes in specific demographic groups.

- **Future Work:** Longitudinal studies, incorporation of genetic data, and integration with electronic health records.
had the gene rearrangement RUNX1-ETO (9q34;21q22), consistent with the conventional cytogenetic finding of t(9;21) (q34;q22) in two of the patients. Mutations in RUNX1 were present in 11.7% of our patient cohort, with 2.6% occurring in association with t(9;21) (q34;q22).

The t(8;21)(q22;q22) DEK-CAN1274 was diagnosed in one patient by conventional cytogenetics. Concomitant with the presence of t(8;21), t(6;9)(p23;q34) in one patient (1.3%). In total, 53 patients (68.8%) underwent additional evaluation for the presence of mutations in NPM1, CEBPA, FLT3, or C-KIT. Also considered to be investigational, molecular genetics studies evaluating the presence of fusion genes were performed in 15 patients (19.5%): 13 patients were assessed for PML/RARA in cases with a known t(15;17), and two patients for BCR-ABL. Of those evaluated, eight patients demonstrated the presence of the PML-RARA fusion gene, and both analyses for BCR-ABL were negative. Overall, the rates of conventional and molecular cytogenetic evaluation of patients presenting to Baylor University Medical Center at Dallas undergo thorough diagnostic evaluation in keeping with current recommendations. In addition, a large portion of patients had further genetic and molecular evaluations, which although considered optional or investigational by current recommendations have prognostic significance. While the additional useful and prognostically significant testing is frequently performed, we did find that the positivity rate did vary from year to year. This testing needs to be more specifically defined. Currently, we are investigating having patients undergo reflex genetic testing to better define their specific disease while avoiding unnecessary genetic evaluations which come at increased cost. Reflex testing has been adopted at Baylor University Medical Center for specific types of lung, colon and uterine cancer and is being discussed for several others. Our study did not evaluate how choice of therapy or overall survival were influenced by the additional genetic and molecular evaluations, however complete information allows for the most informed treatment planning. Only 49% of patients with AML received upfront HLA testing, including 57% in the intermediate and high-risk groups, and 60% in those under 60. It should be a goal to provide HLA testing as early as possible in those patients who may benefit from allogeneic transplant to avoid delays in identifying a donor. The hope is that continued efforts to obtain all available prognostic information and biomarkers translate to improvements in treatment and patient survival.

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Based on the European LeukemiaNet 2010 guidelines, in addition to mutation testing of the NPM1, CEBPA, and FLT3-3 genes, testing for the presence of mutations in other genes such as KIT was considered investigational. Of the 20 patients who underwent KIT mutation analysis, the testing was only relevant in one patient. For the population of people undergoing diagnostic evaluation, rates of mutation analysis over time were fairly consistent being 72% in 2010 and 68% in 2011, and in 68% of cases in 2012. The expert recommendations on behalf of the European LeukemiaNet published in January 2010, mutation analysis for the presence of mutations in the NPM1, CEBPA, and FLT3 genes were considered an optional assessment at the time of diagnosis for all patients in our cohort. More specifically, these mutation analyses were only considered of prognostic significance, and therefore were only recommended as an optional assessment in patients with t(9;21); 83% had molecular cytogenetic evaluation. The results were again similar in 2012 with 21 of 22 patients having conventional cytogenetic analysis and 18 of 22 having molecular cytogenetic evaluation.

Patient evaluation and characterization by molecular diagnostics was consistent with the presence of the K-RAS mutation in 20 patients (26.0%), and positive in only one of those cases (5.0%). In total, 50 patients (68.8%) underwent additional evaluation for the presence of mutations in NPM1, CEBPA, FLT3, or C-KIT. Also considered to be investigational, molecular genetics studies evaluating the presence of fusion genes were performed in 15 patients (19.5%): 13 patients were assessed for PML/RARA in cases with a known t(15;17), and two patients for BCR-ABL. Of those evaluated, eight patients demonstrated the presence of the PML-RARA fusion gene, and both analyses for BCR-ABL were negative. Overall, the rates of conventional and molecular cytogenetic evaluation of patients presenting to Baylor University Medical Center at Dallas undergo thorough diagnostic evaluation in keeping with current recommendations. In addition, a large portion of patients had further genetic and molecular evaluations, but these mutation analyses were performed only in 18 of the 24 patients. Moreover, these analyses were also performed in 31 patients without t(8;21).

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Gliomas are tumors that arise from glia, or support cells from within the central nervous system. Grade II gliomas, or glioblastomas (GBM), is the most common and most aggressive glioma in humans. Unfortunately, GBMs are very intractable, and the median survival remains dismal at 14.3 months with standard therapy. Based on data from the Central Brain Tumor Registry of the United States, 15.6% of all brain tumors are GBMs, and 45.2% of malignant brain tumors are GBMs. They are more common in older adults and are approximately 1.5 times more common in men than women. The 5-year survival of patients with GBMs is poor, normally less than 5%. Thus, GBMs are one of the most challenging types of brain tumors to treat. With research dedicated to better understanding this disease, along with clinical trials testing new treatments, survival is improving. It is important that patients receive the standard care according to National Comprehensive Cancer Network (NCCN) guidelines or enroll in clinical trials to add to our knowledge base and improve their chances of survival.

We determined how radiation treatment of patients at Baylor University Medical Center at Dallas (Baylor Dallas) from 2010 to 2012 compared with NCCN guidelines. Treatment for GBM includes a combination of surgery, radiation treatment, and chemotherapy. The recommended radiation dose for high-grade glioma is 60 Gray (Gy) in 1.8- to 2.0-Gy fractions. A slightly lower dose of 55 to 57 Gy can be applied when the tumor volume is very large, such as in gliomatosis or grade III astrocytomas. For debilitated patients or the elderly, a hypofractionated accelerated course of 3 to 4 weeks with a total dose of 45 to 50 Gy has also been found to be effective.

**Results**

A total of 39 patients were diagnosed with GBM at Baylor Dallas from 2010 to 2012. Of these 39 patients, 37 patients had surgery. Thirty of these 37 patients received chemotherapy. In the remaining 9 patients, four refused chemotherapy and five died prior to the recommended therapy. Among those who died, one patient had Gliadel® wafers implanted at the time of surgery and died before planned systemic therapy. Of the patients treated at the Baylor Dallas campus from June 2013, 30 patients received radiation therapy. Among the nine patients who did not receive radiation therapy, four declined it and five died prior to the recommended treatment. Of the 30 patients who were treated with radiation therapy, 27 had it up to the recommended 35 to 60 Gy of radiation, and three patients received less than the recommended dose (30 patients who were treated with radiation therapy, 27 patients received some of their care at Baylor Dallas from 2010 to 2012. Of these 27 patients, 24 underwent surgery to remove all or part of their tumor, and 22 received chemotherapy. Among those who did not receive chemotherapy, for one patient it was not recommended; another patient refused treatment, two patients died before they could get the recommended treatment, and the other patient was referred to but was never seen by Dr. Fink, so was lost to follow-up. Finally, these same 22 patients out of 27 who received chemotherapy also received radiation therapy. Of the 22 patients who did receive radiation therapy, 20 received the full 60-Gy doses, while one received a total only 32 Gray fractions, expiring before the end of treatment. The remaining patient received radiation treatment, but at an unknown dosage.

Thus, for patients treated entirely at the University Medical Center at Dallas (Baylor Dallas) from 2010 to 2012, we determined how radiation treatment of patients at Baylor Dallas, the NCCN guidelines were followed regarding radiation treatment of GBMs. When patients did not receive the recommended treatment, the reason was the death of the patient or patient choice, not any decisions made by their oncologist.


Baylor Sammons Cancer Center and Baylor T. Boone Pickens Cancer Hospital are located on the campus of Baylor University Medical Center at Dallas, and are accessible from U.S. 75 (North Central Expressway/I-45) and I-30.

A map on the facing page illustrates highway access to the medical center.

Valet parking is available at the front entrance and other nearby locations.

Self-parking is conveniently located adjacent to Baylor Sammons Cancer Center in garage 4.

Self-parking for the new Baylor T. Boone Pickens Cancer Hospital is available in garage 4 or valet in front of the hospital.

The campus is also accessible via the DART Green Line to Baylor University Medical Center station. Baylor Sammons Cancer Center is a two-block walk.
Beating Cancer