



Committed to Improving  
Cancer Care.

2015 Fargo Cancer Committee Annual Report

**SANFORD**<sup>®</sup>  
ROGER MARIS  
CANCER CENTER





Roger Maris  
Cancer Center  
820 Fourth St. N.  
Fargo, ND 58102  
(701) 234-6161

## 2015 Sanford Medical Center Cancer Committee Membership

**Cancer Committee Chair**  
John Leitch, MD

**Diagnostic Radiologist**  
Dan Mickelson, MD

**Pathologist**  
Julie Lessard, MD

**General Surgeon**  
Erik Fetner, MD

**Medical Oncologist**  
Mark Gitau, MD

**Radiation Oncologist**  
Dennis Bier, MD

**Cancer Liaison Physician**  
Michael Bouton, MD

**Cancer Program  
Administrator**  
Kathy Hanish, MSN, RN

**Oncology Nurse**  
Theresa Larson,  
MSN, RN, OCN/  
Tom O'Keefe, MSN, RN

**Social Worker or  
Case Manager**  
Cheryl Smith, LICSW, MSW

**Certified Tumor Registrar**  
Jennifer Monsebroten, CTR

**Quality Management  
Representative**  
Kelly Counihan, RN

**Psychiatric or Mental Health  
Professional**  
Cheryl Hysjulien, RN, PsyD

**Genetic Professional/  
Counselor**  
Lauryn LaPoint, MS, LCGC

**Clinical Research  
Representative**  
Melissa Burgard,  
MSW, CCRC

**Palliative Care Team Member**  
Tom O'Keefe, MSN, RN

**Manager of Oncology  
Education, Registry &  
Programs**  
Barbara Sherburne,  
MS, RN, OCN

**Primary Care Physician**  
Janelle Sanda, MD

**Director of Medical,  
Radiation, & Pediatric  
Oncology & Breast Clinic**  
Amy Arel, BSN, RN, OCN

**Oncology Service Chair,  
Medical Oncology**  
Anu Gaba, MD

**Oncology Education**  
Mary Sahl, BSN, RN, OCN

**Recording Secretary**  
Tracy Strendin

**AD HOC for Pediatric  
Oncology issues**  
Samuel Anim, MD

**AD HOC for Pediatric  
Oncology issues**  
Nathan Kobrinsky, MD

**AD HOC for Urologic Oncology  
issues**  
Theodore Sawchuk, MD

**AD HOC American Cancer  
Society Representative**  
Sara McGauvran

**AD HOC Director of  
Center for Learning**  
Terri Hedman, MSSL,  
BSN, RN, OCN

**Cancer Conference  
Coordinator**  
John Leitch, MD

**Quality Improvement  
Coordinator**  
Kelly Counihan, RN

**Cancer Registry Quality  
Coordinator**  
Jennifer Monsebroten, CTR

**Community Outreach  
Coordinator**  
Mary Sahl, BSN, RN, OCN

**Clinical Research Coordinator**  
Melissa Burgard,  
MSW, CCRC

**Psychosocial Services  
Coordinator**  
Cheryl Hysjulien, RN, PsyD



Paul Richard

## A Letter from Sanford Medical Center Fargo President Paul Richard

This year, Sanford Roger Maris Cancer Center celebrates 75 years as an accredited cancer program by the Commission on Cancer (CoC), a program of the American College of Surgeons. This is a truly unique and prestigious accomplishment as we are one of very few facilities in the United States to achieve at least 75 years of continuous accreditation. One of the founding fathers of St. Luke's Hospital/Fargo Clinic (now Sanford Health) deserves our thanks—Dr. O.J. Hagen.

Highly educated and respected in his field, Dr. Hagen was a long-time supporter of continuing education. He studied radium physics at the University of Minnesota during the 1930s and brought a new idea to the St. Luke's Hospital Board of Directors on Aug. 30, 1939. He noted statistics showed cancer cures were possible because of early diagnosis and treatments available at the time: surgery, X-ray and radium. He also noted St. Luke's had competent medical and surgical staff, clinical pathological laboratories and the necessary X-ray and radium facility to establish St. Luke's Hospital Cancer Institute. He pushed the Board to sponsor a public cancer education program through the American Society for the Control of Cancer and spread the word with the slogan: Fight Cancer with Knowledge. The Board approved the motion to establish St. Luke's Hospital Cancer Institute, and the rest is history.

Today's cancer care is light years ahead of 1939, but the idea fostered by Dr. Hagen is still relevant—high quality, comprehensive, multidisciplinary patient-centered cancer care close to home. Accreditation by the CoC recognizes our dedication to improve survival and quality of life for patients through standards of care, prevention, research, education and monitoring.

Congratulations and thank you to all involved in the care of patients at Roger Maris Cancer Center. We are proud to be able to provide first-class cancer care close to home for decades to come.

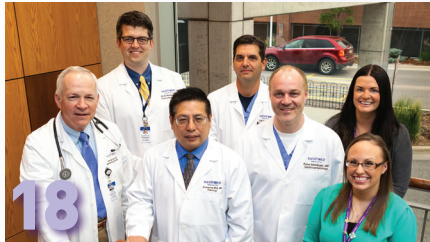
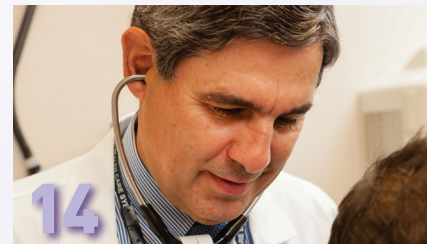
Sincerely,

A handwritten signature in dark ink that reads "Paul F. Richard". The signature is written in a cursive, flowing style.

Paul Richard  
President, Sanford Health Fargo



# Table of contents



- 6 Year in review
- 7 Proven quality
- 8 Expertise
- 9 Team of experts
- 10 The benefits of a cancer registry
- 14 A service to the community
- 15 For now. For the future.
- 16 The gold standard

- 17 Fighting cancer at the genetic level
- 18 A multidisciplinary approach to care
- 20 All for you
- 21 Marked for expert care
- 22 Forward thinking
- 25 An emotional journey
- 26 Life after cancer
- 27 Thank you





# Roger Maris Cancer Center Medical Staff



Ammar Alzoubi, MD  
Hematology/  
Medical Oncology



Samuel Anim, MD  
Pediatric Oncology/  
Hematology



Robert Arusell, MD  
Radiation Oncology



Dennis Bier, MD  
Radiation Oncology



Miran Blanchard, MD  
Radiation Oncology



Ethan Foster, MD  
Radiation Oncology



Anu Gaba, MD  
Medical Oncology/  
Hematology



Louis Geeraerts, MD  
Medical Oncology/  
Hematology



Mark Gitau, MD  
Medical Oncology/  
Hematology/  
Palliative Care



Gerald Gross, MD  
Medical Oncology/  
Hematology



Ashley Jensen, MD  
Radiation Oncology



Nathan Kobrinsky, MD  
Pediatric Oncology/  
Hematology



John Leitch, MD  
Medical Oncology/  
Hematology/  
Palliative Care



Ralph Levitt, MD  
Medical Oncology/  
Hematology



Pamela McGrann, MD  
Medical Genetics



Amit Panwalkar, MD  
Medical Oncology/  
Hematology



Homayoon Shahidi,  
MD  
Medical Oncology/  
Hematology



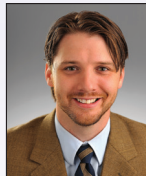
Denise Snow, MD  
Medical Oncology/  
Hematology



Preston Steen, MD  
Medical Oncology/  
Hematology/  
Palliative Care



Shelby Terstriep, MD  
Medical Oncology/  
Hematology/  
Palliative Care



Matthew Tinguely, MD  
Medical Oncology/  
Hematology



Chery Hysjulien,  
PsyD  
Clinical Psychology



Annie Berger, PA  
Medical Oncology



Susan Hofland,  
FNP-C, Medical  
Oncology/  
Hematology



Jana Suder,  
DNP, NP-C  
Hemophilia/  
Thrombophilia



Erin Welle, PA-C  
Medical Oncology/  
Hematology



Lori Wolf, FNP-C  
Medical Oncology/  
Hematology





# Roger Maris Cancer Center Annual Report Year in Review



John Leitch, MD  
Chair,  
Cancer Committee

Thank you for taking the time to read our annual report. It has been another busy and rewarding year at Sanford Roger Maris Cancer Center and I am excited to share some of our highlights with you.

I am very proud to announce that this is our 75th year as an accredited cancer center by the American College of Surgeons. We were awarded a commendation for excelling in certain cancer program areas including the number of patients enrolled in clinical research trials, the effectiveness of our cancer registry and the overall quality of care we provided. Our surveyor selected some of our programs such as Sanford Cancer Survivorship, to share as models of care with other American College of Surgeon's accredited cancer centers.

In this year's annual report, we give special attention to patients with colorectal cancer. In 2014 at Sanford Roger Maris Cancer Center, there were 158 colorectal cancer cases, 74 (47 percent) of which were more advanced (stage 3 or 4). Our treatment results compared favorably with other cancer centers in the region and nationally.

Ideally we want to detect cancers at earlier stages (stage 1 or 2), when there is a better chance for cure. Sadly in North Dakota we are at the bottom third of the country for colorectal cancer screenings, which leads to later detection and more advanced colorectal cancer stages. Higher screening rates and

early intervention are key to helping improve these numbers. Colorectal cancer screening can also detect precancerous polyps which, if removed, can prevent colorectal cancer and reduce an individual's colorectal cancer risk by 50 percent.

To aid in the goal to improve colorectal cancer screening, Sanford Health is committed to having at least 80 percent of eligible patients screened for colorectal cancer using fecal occult blood tests or colonoscopy by the year 2018.

Throughout this report you will see the many other ways we are committed to improving cancer care. It is our goal to provide the best care possible with the support and coordination of care that everyone deserves.

John M. Leitch, MD







## Proven quality

Roger Maris Cancer Center holds a number of accreditations. Accreditation is a voluntary process in which outside reviewers closely examine our program and our results. If we meet or exceed specific standards, we receive the stamp of approval. For patients and families, accreditation is an important measure of quality.

- Accreditation of Sanford Medical Center by The Joint Commission (TJC)
- The accreditation of Sanford Medical Center by the American College of Surgeon's Commission on Cancer. The most recent accreditation in April 2015 was awarded at the Silver Commendation level. In 2015 we celebrate 75 years of continuous accreditation, going back to 1940, reflecting a long history of quality care.
- Accreditation by the National Accreditation Program for Breast Centers (NAPBC) through the American College of Surgeons
- Accreditation by the American College of Radiology – Radiation Oncology
- Edith Sanford Breast Health Comprehensive Center (Fargo) recognized as a Certified Quality Breast Center of Excellence through the National Consortium of Breast Centers. (NQMBC)
- Breast Imaging Center of Excellence (BICOE) through the American College of Radiology
- Advance Care Certification by TJC for Palliative Care Services
- Certification by the Quality Oncology Practice Initiative (QOPI) through the American Society of Clinical Oncology





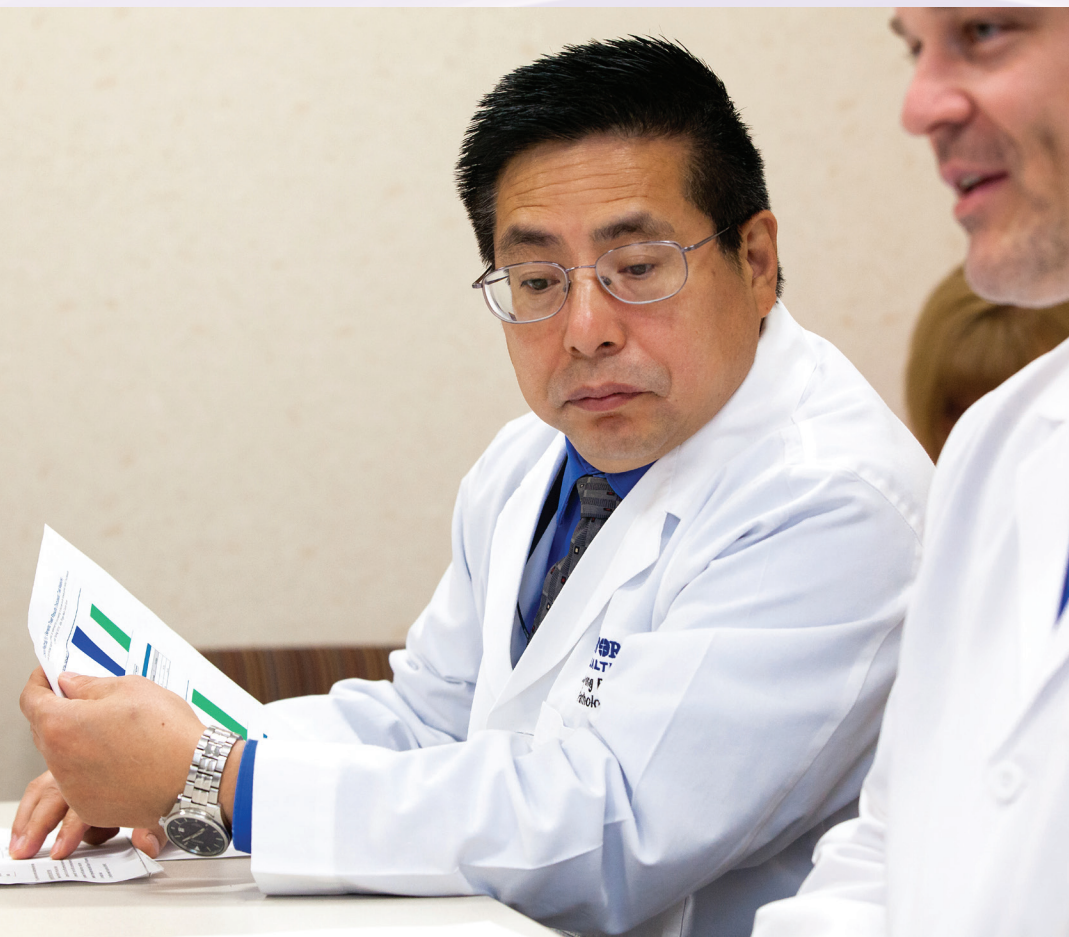
# Expertise

## Comprehensive care provided

- 32-bed oncology unit
- 8-bed palliative care unit
- Infusion center
- Radiation therapy
- Hemophilia/thrombosis care
- Point of care testing lab
- Pharmacy
- Nutrition services
- Psycho-oncology services
- Spiritual care
- Financial services
- Massage therapy
- Artist in residence
- Cancer survivorship
- Patient and family education
- Research
- Bedside palliative care program
- Cancer registry







## Team of experts

- 13 Medical oncologists/hematologists
- 5 Radiation oncologists
- 2 Pediatric oncologists/hematologists
- 7 Palliative care board certified physicians
- 1 Oncology clinical psychologist
- 1 Medical geneticist
- 3 Genetic counselors
- 1 Doctor of nursing practice
- 2 Physician assistants
- 2 Nurse practitioners
- 10 Oncology nurse navigators
- 186 other nurses (173 RN's and 13 LPN's)
- 74 Chemotherapy trained RN's
- 56 RN's holding oncology specialty certifications: 52 oncology certified nurses (OCN), 2 certified pediatric hematology and oncology nurses (CPHON) and 2 certified breast patient navigators in imaging and cancer (CBPN-1C)
- 7 Pharmacists
- 7 Pharmacy technicians
- 3 pharmacy interns
- 11 Radiation therapists
- 4 Radiation oncology medical physicists
- 5 Medical dosimetrists, 1 dosimetry assistant
- 3 Radiation simulation therapists
- 2 Social workers
- 6 Cancer registrars
- At least 90 additional staff in administrative, office and supportive care roles



# The benefits of a cancer registry at Roger Maris

The eight-member Cancer Registry team at Sanford Roger Maris Cancer Center manages a massive database tracking all the cancer patients treated at Roger Maris. Their work helps to guarantee our patients receive the best care by entering the information about every patient's diagnosis into the cancer registry database. This data is then used to track the patient's care, long-term survival and quality of life.

“Data like this is so helpful in ensuring we are meeting treatment guidelines,” says Jenny Monsebroten, the cancer registry supervisor at the cancer center. “It shows the treatment that was used and how the patient responded to it. It's a great indicator of the type of top-quality care that is offered here.”

Having a registry database also ensures Roger Maris is matching the standard of care delivered at other hospitals in the area and across the country.

The database keeps records of everything about the patient from where they live and how old they are to where the cancer was located, the stage at diagnosis and what treatments were given.

In addition, the cancer registry tracks the volume of patients treated at the hospital for each type of cancer. The more patients an institution treats means the doctors and staff gain more experience. This translates into better care and a broader knowledge base. It also can help show which types of cancers are becoming more prevalent in the

area and how Roger Maris can better serve those patients' needs, whether it means more specialists or different equipment.

The data from the Roger Maris cancer registry is sent to state and national databases, so that Roger Maris information contributes to national statistics on cancer. The compiled data also helps local, state and national cancer agencies make important public health decisions to maximize the effectiveness of limited public health funds. The combined data also allows researchers and physicians can learn more about the causes, diagnoses and treatment of cancer.

At the heart of registering all this data is the goal to make sure patients and their families are receiving the best care available.





# Rapid Quality Reporting System

## Dashboard Results

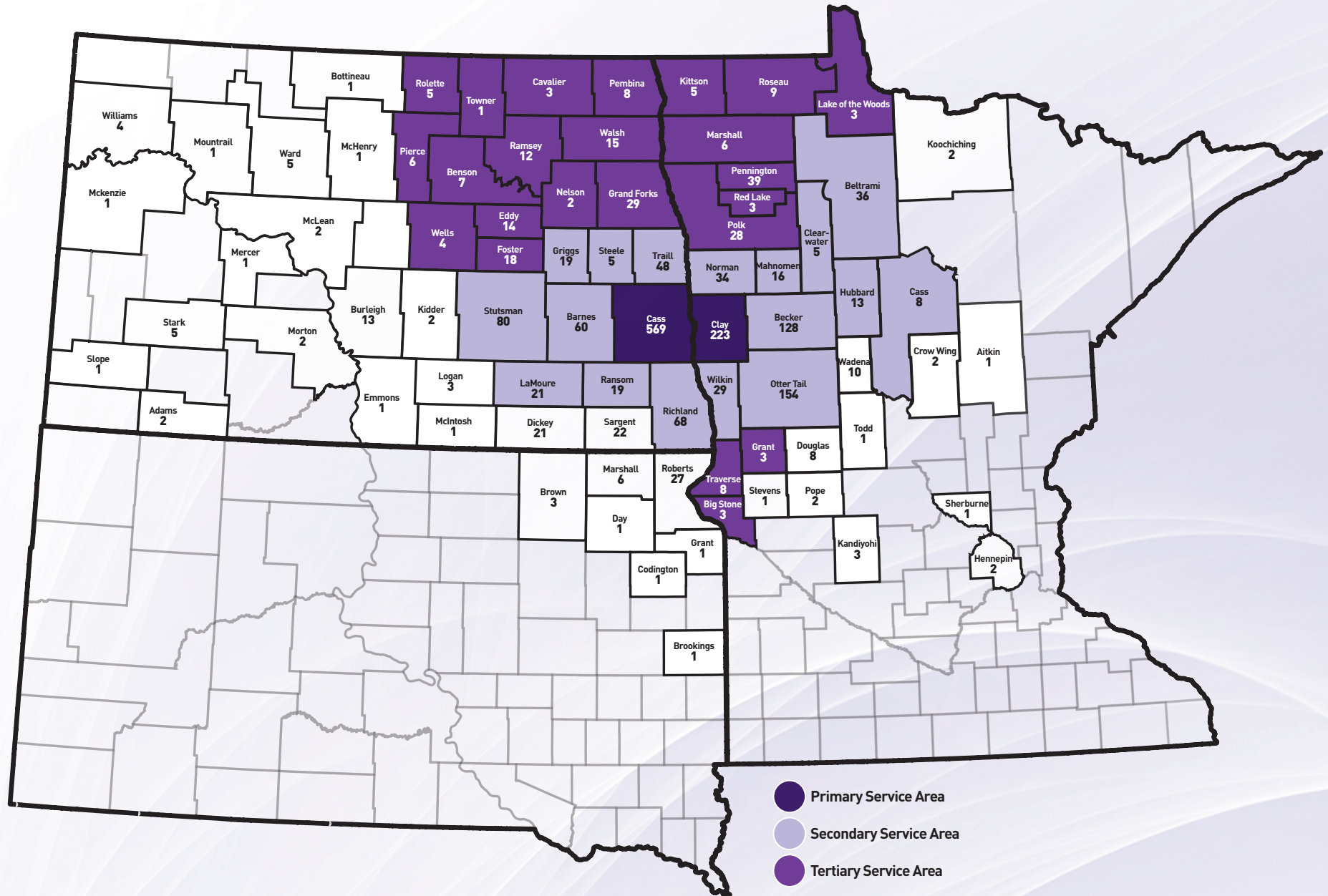
Breast Measures		
<b>98.40%</b> Radiation therapy is administered within one year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer.	<b>100.00%</b> Combination chemotherapy is considered or administered within four months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, or stage IB-III hormone receptor negative breast cancer.	<b>99.40%</b> Tamoxifen or third generation inhibitor is considered or administered within one year (365 days) of diagnosis for women with AJCC T1cN0M0, or stage IB-III hormone receptor positive breast cancer.

Colon Measures	
<b>85%</b> At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.	<b>100%</b> Adjuvant chemotherapy is considered or administered within four months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer.

These results meet national quality standards for treating breast and colon cancers.



# Geographic distribution of primary cases 2014





Site	2014	Male	Female	2013	Male	Female
Breast	320	4	316	282	1	281
Lung & bronchus	208	109	99	209	115	94
Prostate	172	172	0	183	183	0
Melanoma, skin	154	81	73	177	95	82
Colon	103	50	53	103	39	64
Lymphoma	89	43	46	64	28	36
Non-Hodgkin	81	38	43	52	19	33
Nodal	47	24	23	28	11	17
Extranodal	34	14	20	24	8	16
Hodgkin	8	5	3	12	9	3
Bladder	86	67	19	86	64	22
Leukemia	71	42	29	63	36	27
Lymphocytic	39	22	17	34	18	16
ALL	10	5	5	5	3	2
CLL	29	17	12	27	13	14
Other	0	0	0	2	2	0
Myeloid	29	18	11	26	17	9
AML	20	11	9	19	11	8
CML	8	6	2	6	5	1
Other	1	1	0	1	1	0
Other leukemias	3	2	1	3	1	2
Brain	31	18	13	35	19	16
Other CNS	40	6	34	49	15	34
Kidney	72	52	20	54	34	20
Pancreas	50	28	22	61	42	19
Rectum/rectosigmoid	55	35	20	49	20	29
Uterus	54	0	54	42	0	42
Cervix	7	0	7	3	0	3
Ovary	18	0	18	18	0	18
Stomach	14	6	8	29	18	11
Esophagus	26	19	7	20	13	7
Oral cavity/pharynx	47	36	11	61	41	20
Multiple myeloma	25	14	11	23	14	9
Thyroid	104	21	83	88	21	67
Testis	12	12	0	11	11	0
Soft tissue	10	3	7	13	7	6
Larynx	8	6	2	11	10	1
Liver/IBD	29	21	8	14	9	5
Mesothelioma	0	0	0	11	9	2
Small intestine	11	7	4	8	3	5
Anus	3	0	3	3	0	3
Vulva	5	0	5	3	0	3
Ureter	3	2	1	3	3	0
Other sites	115	56	59	115	56	59
<b>Total</b>	<b>1942</b>	<b>910</b>	<b>1032</b>	<b>1891</b>	<b>906</b>	<b>985</b>

## Primary cancer site distribution for Sanford Roger Maris Cancer Center





# A service to the community

## Providing screening colonoscopies to those in need

Preventive care is essential to a healthy life. But many people in the Fargo/Moorhead area are unable to afford the screenings that could save their lives.

“Most people are unaware that finding colon polyps early, before any cancer can develop, is the right time to find them,” says Mary Sahl, colorectal screening coordinator. “Colon polyps can be detected and removed via a colonoscopy. It seems like a practical solution, but our state rates for screening are among the lowest in the nation.”

There are many barriers for screening including cost, lack of health insurance coverage and no insurance. Improving access for colorectal cancer screening was the goal of the Colorectal Screening Grant provided by the North Dakota State Legislature. It was administered through the Sanford Fargo Endoscopy department in coordination with the North Dakota Department of Health and the Education Department at Sanford Roger Maris Cancer Center.

“Through three consecutive grants, we were able to provide colonoscopies to

people who were due for a screening and met certain income guidelines,” says Sahl. “We’ve been able to provide this service for the past six years, and last year alone we screened 68 people, 32 of whom had adenomatous polyps, which may develop into cancer if left undetected. That number is more than triple the average detection rate and really shows just how important these preventive screenings are.”

And those above average numbers aren’t an anomaly. North Dakota has one of the highest incidence rates for colorectal cancer in the country. In fact, for every 100,000 people, there are 47 new cases of colorectal cancer each year in North Dakota. That is compared to the national average of 42 per 100,000 (statecancerprofiles.cancer.gov). North Dakota also has one of the lowest rates for colorectal screenings in the country with only 58 percent of people eligible receiving the proper colorectal screenings according to a 2013 study. (2013 BRFSS data, <http://www.ndhealth.gov/brfss/>)

This grant program is aimed at improving those numbers by expanding the reach of



services to those who were unable to afford them or were not covered by insurance.

The state-funded grant, as it was structured, concluded in 2015. All participants received letters which included their next recommended screening date, along with options for future screenings. With the Affordable Care Act now offering insurance coverage to millions of Americans, preventive screening options are now more accessible to those who need them.



# For now. For the future.

## Clinical trials for colorectal cancer patients

The interesting thing about clinical trials is that they are one of the only ways in which one patient's treatment could directly affect another's.

"This is how progress is made," says Preston Steen, MD, a medical oncologist and the Medical Director for Clinical Research at Sanford Roger Maris Cancer Center. "In the '90s, people would receive chemotherapy for a year for stage III (lymph node positive) colon cancer. Now we know that six months

is just as effective without the added side effects of doing chemo for a whole year. And that's thanks to clinical trials."

And now the team at Roger Maris is seeing if treatment can be improved even more with three clinical trials dedicated to colorectal cancer. The first is investigating three vs. six months of chemotherapy for patients with stage III colorectal cancer where the cancer has moved into the lymph nodes. The second study is for patients with recurrent

colon cancer to determine if adding a new drug to a standard regimen will be more effective. The third uses a targeted agent for a small subset of patients whose colon cancer has an unusual genetic mutation.

Patients at Roger Maris have access to these trials in part thanks to a partnership with the National Cancer Institute's Community Oncology Research Program (NCORP). As one of only 34 NCORP sites across the nation, RMCC can enroll patients in cutting-edge treatments that will benefit not only them, but also future colorectal cancer patients. The affiliation with NCORP provides clinical trial opportunities for many other cancer types, as well.

"This is evidence-based medicine," says Dr. Steen. "It's not something we just decide to try and see what happens. All of these trials have been tested and gone through a process to make sure they are safe and could potentially help our patients. They really help us answer treatment-related questions and are essential to the advancement of cancer care."





# The gold standard

## Ensuring patients receive the best care

Every patient wants the best care, and at Sanford Roger Maris Cancer Center, all patients are guaranteed the “gold standard.” This means the care they receive is the best available and has met the guidelines from the National Comprehensive Cancer Network, a national best-practice resource.

“To ensure we meet these standards of care, we do an audit of our cancer cases every year,” says Erik Fetner, MD, colorectal surgeon. “This year the audit was on the rectal cancer cases. We have the most recent data available from our cancer registry. This database is updated continuously and it tells us how many cases of rectal cancer we saw, where the patients were from, how old they were at diagnosis, what each treatment plan entailed and anything else pertinent to their care.”

Roger Maris met all best practice requirements and has for a number of years. The evaluation shows that 100 percent of all rectal cancer patients were offered the latest options and the best care available. However, not all patients elected to have the treatment that was suggested.

“Cancer is a very personal disease and all patients have the right to make the decision that is best for them and their family,” says Dr. Fetner.

Dr. Fetner says he is extremely pleased with the results of the evaluation, but it is just what he expected.

“We strive to give our patients the best care possible,” says Dr. Fetner. “With the implementation of our tumor board and the GI oversight committee, we are confident our patients are getting exactly what they need.”



2014 Statistics					
Colorectal patients		Colon		Rectal	
Colon	103	Stage 0	1	Stage I	13
Rectal	55	Stage I	20	Stage II	14
		Stage II	32	Stage III	16
		Stage III	32	Stage IV	12
		Stage IV	14		
		Unknown State	4		



# Fighting cancer at the genetic level

## The importance of a genetic risk assessment

For 5-10 percent of patients with colorectal cancer, an inherited genetic mutation plays a role in the development of their cancer. At Roger Maris Cancer Center, patients may be referred to the cancer risk assessment department, where geneticist Dr. Pamela McGrann and a team of genetics counselors determine whether heredity was a factor in the patient's cancer.

After the patient completes a family cancer history profile, they meet with a member of the genetics team to review the information and then decide whether a blood test to look for a genetic mutation is recommended.

### **Familial cancer syndromes**

There are several inherited colorectal disorders that are passed down from parent to child, including Lynch syndrome, familial adenomatous polyposis, Cowden syndrome, Peutz-Jeghers syndrome and Li-Fraumeni syndrome. "Identifying these individuals with familial colorectal syndromes is very important," says Dr. McGrann. "These syndromes are autosomal dominant disorders, meaning all offspring and typically any siblings will have a 50 percent chance of having it as well."

### **Care designed by DNA**

Having one of the familial cancer syndromes, such as Lynch, increases the likelihood of developing cancer, causes colorectal cancer to appear at an earlier than average age, and makes the person prone to other cancers as well. To help patients in this situation, Roger Maris Cancer Center has a familial cancer syndrome clinic, where the team assists in

Identifying these individuals with familial colorectal syndromes is very important.

coordinating care and helping individuals with an increased risk of cancer to plan for future screenings. This type of genetic knowledge is invaluable. It will help customize the patient's treatment plan and inform close relatives of the possible risk that they might be carriers of the mutation as well.



# A multidisciplinary approach to care

## Where an entire team of experts is focused on you



Dennis Bier, MD



Robert Sticca, MD

At Sanford Roger Maris Cancer Center, patients who are diagnosed with colon or rectal cancer work with many experts, to make sure care is up to the highest standards. From nurse navigators to physicians, each person on the cancer team brings a unique contribution to their care. And while it might seem overwhelming to meet with and be treated by so many people, at Roger Maris these specialists work together seamlessly. This multidisciplinary team ensures that each patient's care plan has been thoroughly vetted and developed specifically with the individual patient's needs in mind.

### It all starts here

For most colorectal patients, their journey starts with an endoscopy. Once a diagnosis is confirmed through biopsy, the patient is contacted by an oncology nurse navigator, whose role is to coordinate the care needed at the time of diagnosis. The navigator helps schedule all the necessary appointments and procedures so that patients have the most efficient and thorough timeline of care and treatment.

“We also educate them about their diagnosis, answer questions, connect patients to other support services and provide comfort and support during the early phases of their care. I enjoy being a person patients can rely on as they begin their cancer journey” says Julie Martin, GI Oncology nurse navigator.

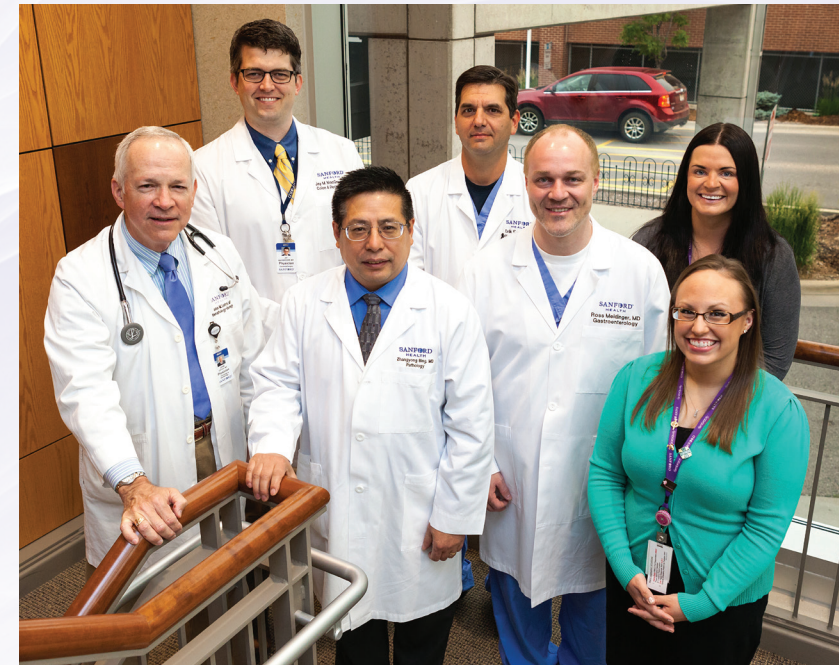
All of this new information can be overwhelming for patients. Having dedicated support helps to clarify the initial diagnosis and staging.

### Staging

One of the first appointments the navigator will make is for staging. Staging determines the extent

of the cancer and how far it has spread. Determining the stage of the cancer is essential in knowing how to proceed. For all patients with colorectal cancer, this will include CT scans and blood tests. Patients who have rectal cancer are scheduled for an additional test. In that case, Ross Meidinger, MD, a Sanford gastroenterologist, is usually one of the first team members to interact with the patient.

“We use endoscopic ultrasounds to determine the stage of the rectal cancer,” says Dr. Meidinger. “I look at the depth of the tumor, if it is in the lymph nodes and if it has metastasized. There are five different tissue layers, and depending on how far the tumor has moved through the muscle wall will help in determining the stage. The stage then helps to narrow down what type of treatment should be recommended.”





### **A team plan**

Patients will then begin meeting with the doctors who will be handling their care. This includes surgeons, medical oncologists, radiation oncologists and any others whose expertise are needed for each specific case. For patients with colon cancer that has not spread to other sites in the body, the first stop is a consult with one of Sanford's colorectal surgeons. In addition to the surgeon, patients with rectal cancer also consult with medical and radiation oncologists. After considering patients' test results and preferences, a treatment plan is proposed. Sometimes before any major intervention happens, new colorectal cases are brought forward at a GI cancer case conference. At these regularly scheduled meetings, members from each area of the cancer care team look carefully at the patient's unique situation and the best medical evidence for treatment.

"You have all of these experts from multiple disciplines of medicine in one room looking at patient cases," says Erik Fetner, MD, a colorectal surgeon. "These doctors each have seen a variety of cases and have had so many different experiences when it comes to cancer that one might have a different perspective or insight that might help a patient with an unusual case or atypical symptoms. This ensures we are proceeding with the best plan for each patient."

### **Time for treatment**

Depending on the patient, treatment could mean chemotherapy, radiation, surgery or a combination of all three. This takes coordination with all doctors involved to make sure the patient understands the plan and feels that they are a part of the decision making process.

Patients with colon cancer, which is localized to the colon and not spread elsewhere, usually have surgery first. After surgery they consult with a medical oncologist to determine if chemotherapy is needed, and plan for long-term follow-up. Depending on the results of surgery, patients may also consult with a radiation oncologist. Many patients with rectal cancer first receive chemotherapy and radiation treatments at the same time, followed by surgery and then more chemotherapy. This sequence of care can take nearly a year, from diagnosis to completion of treatment. The team works hard so that patients do not fall through the cracks in the transitions through the various kinds of treatments.

If patients have metastatic colon or rectal cancer, spread to another part of the body, they take a different pathway. Often they start with chemotherapy and then have other treatments, depending on their response to the chemotherapy. Another



article in this report features some other treatment options for patients with metastatic disease.

### **The best for patients**

All of these moving pieces are coordinated seamlessly to provide an exceptional care experience for patients.

"Patients are already going through what is probably one of

the most difficult times in their lives," says John Leitch, MD, hematologist/oncologist. "With our organized approach to care, we can make sure that all of their energy is spent on getting better instead of worrying about appointments and whether or not their care team is talking to one another. Our coordinated process ensures the highest level of care for every patient."

**Our coordinated process ensures the highest level of care for every patient.**



# All for you

## How a multidisciplinary team is helping one Sanford patient through an unexpected diagnosis

For most people, a colonoscopy is not something you have to think about until after your 50th birthday. However, Jason Lundblad had his first colonoscopy much sooner than the average person.

Jason was just 36 when he started having severe stomach pain. He was soon at Sanford having a CAT scan to find out what was causing his pain. The results were jarring. He had a large, near obstructing tumor in his colon.

“While most colon cancer cases occur in people over 50, anyone can be diagnosed with colon cancer, regardless of age or gender,” says Erik Fetner, MD, a colorectal surgeon at Sanford Roger Maris Cancer Center. “And it’s becoming more common in young men like Jason. So if you have any family history of colorectal cancer, talk to your primary care provider about your risk factors and whether you should be screened earlier.”

Dr. Fetner the very next day. He then had a colonoscopy to confirm what was on the scan.

“It all happened pretty quickly,” remembers Jason. “I had surgery that next week and they had to remove six inches of my colon. Then shortly after that, I started my first of 12 rounds of chemotherapy.”

Jason’s cancer was metastatic, meaning it had traveled to other parts of his body. This meant his treatment plan would be fairly intensive. After the first 12 rounds, Jason had what is known as HIPEC (hyperthermic intraperitoneal chemotherapy), which delivers the chemo directly to the cancer cells in the lining of his abdomen, and a debulking procedure to remove as much of the cancerous tissue as possible. Now Jason is on another 12 rounds of chemotherapy. But despite this intense treatment plan, Jason is still working full time and both he and his family are in good spirits.

“The care is exceptional,” says Jason. “My nurse navigator Julie is amazing. She never lets me leave unless all my questions have been answered and I know exactly what is going on. Having her and all the doctors go that extra mile really makes my, and I’m sure a lot of other cancer patients’, journey a lot easier.”

“The Care is Exceptional” - Jason Lundblad

Jason was quickly assigned a nurse navigator who helped arrange an appointment with





## Marked for expert care

### Wound and ostomy care for cancer patients

Some patients with colorectal cancer may require a temporary or permanent ostomy as part of their cancer treatment. An ostomy is a new opening in the abdominal wall where either the small intestine or colon comes through to form a stoma. Stool then passes out of the body through the stoma.

Patients may be stressed and anxious about receiving an ostomy, so Sanford has a team of specially trained nurses, called Certified Wound and Ostomy Nurses (CWON) to calm fears and lessen anxiety through education and reassurance.

The CWON works with patients throughout their journey with an ostomy. Prior to surgery she meets with patients to prepare the patient and family on what to expect and to answer questions. Throughout the patient's post-op stay, the CWON will follow up with ostomy care and ongoing education. The CWON continues to be available to the patient after discharge for any ongoing ostomy needs, such as obtaining just the right supplies or troubleshooting any issues that may arise related to managing life with an ostomy.



# Forward thinking

## Using the latest technology to treat colorectal cancer patients

At Sanford Roger Maris Cancer Center, our teams use some of the latest technology to help patients get the best results from their treatments while doing the least amount of damage to healthy tissue.

Certain patients with colorectal cancer that spreads to limited areas of the body, such as liver only or lung only metastases, can sometimes benefit from new technology.

“In many colorectal cancer cases, the cancer has moved from the colon and grown in other areas of the body, most often in the lungs and liver,” says Dennis Bier, MD, a radiation oncologist. “We can use 3D imaging to precisely map the exact position of the tumor and then through stereotactic body radiation therapy (SBRT), we program radiation beams to hit the tumor at different angles to decrease its size.”

Two-year success rates for SBRT are around 80 to 90 percent compared to 30 to 40 percent for conventional radiation therapy. SBRT offers results comparable to surgery without the associated risks. In fact the most common side effect of SBRT is slight fatigue.

### Options to customize care

This isn't the only option for patients with metastatic cancer. The interventional radiology department can provide a variety of treatments dependent on the patient's situation, including the extent of the tumor, response to chemotherapy and whether or not surgery is an option.

“Before, if the cancer had spread to the liver, there was no option but to remove a huge

portion of the organ and often the patient wouldn't survive,” says Corey Teigen, MD, interventional radiologist. “Now we can use a combination of treatments to spare the liver and ultimately save the patient.”

Some of those options for those with colorectal cancer with metastases to the liver include chemoembolization, radiofrequency ablation, SIR Spheres® and Theraspheres®.

“These are some of the newest modalities available to colorectal patients,” says Dr. Teigen. “With chemoembolization, instead of pumping chemo through the blood system, we bathe the tumor in chemo while a synthetic agent is placed inside the vessels that supply blood to the tumor. By doing this, we can trap the chemo in a small portion of the liver where the tumor is located so no other area of the body is affected.”

Dr. Teigen also implements the groundbreaking SIR Spheres® and TheraSphere® treatments to attack colorectal cancer that has spread to the liver. Both use millions of microscopic, radioactive spheres infused with yttrium-90 (Y-90). Injected directly into the tumor, these microspheres radiate the tumor from the inside out over a period of a few weeks.

### Decisions at a genetic level

All cancers are caused by genetic mutations, some inherited and some happening by chance. Pathologist Zhanyong Bing, MD uses the latest technology and testing methods to help determine the best plan for each patient based on the tumor's genetic profile.

“We use MSI (microsatellite instability) testing to analyze colon tumor samples to see if there are specific gene mutations,” says Dr. Bing. “This can be very useful in determining if the patient has a familial syndrome like Lynch syndrome, and will give us valuable information for forming a treatment plan, as certain common chemotherapy may not work as well with MSI tumors.”

Dr. Bing also performs RAS mutation analysis on metastatic colorectal cases. If the tumor has the RAS mutation, which appears in approximately 40 percent of cases, the patient will not respond to drugs called EGFR inhibitors, which are frequently used to treat colorectal cancers. In that case, a more effective drug can be chosen instead.

Through these innovative treatments and testing capabilities, Sanford Roger Maris Cancer Center is providing care unequalled in the region, giving colorectal cancer patients the chance to have a quality life unimaginable only a few years ago. And RMCC is dedicated to continuously searching for and implementing the latest in technology to make sure these patients always have access to the best in care close to home.

Sanford Roger Maris Cancer Center is providing care unequalled in the region.









live with  
intention

Walk to the edge  
listen hard. Cause  
practice wellness plus  
with abundance. continue to  
learn appreciate you  
friends share with  
no regret

do what you love  
live now  
+ yes is all there is?  
maryanne schmidt





# An emotional journey

## **Facing your feelings when living with cancer**

Cancer is a very difficult medical diagnosis to receive. And while it directly affects your physical health and body, it can take an equally aggressive toll on your mind and spirit. Emotional support during a cancer journey is essential, not just for the patient but for family and friends as well.

Individuals have different emotional reactions to cancer and these can vary throughout cancer diagnosis, treatment, survivorship and possible recurrence. While some may initially feel angry when they are diagnosed, others may experience denial or shock or acceptance. Experiences differ depending on diagnosis, stage, treatment involved, stress level and the individual. There is no right or wrong way to feel because cancer is not fair – it just is!

## **The many emotions of cancer**

The emotions cancer patients experience are fluid and unpredictable, and how they feel about their situation can vary from day-to-day. Shock is common, especially for individuals who may not have been feeling ill. It is difficult for people to believe what is happening and they may initially feel detached from their situation. Denial can also accompany the shock of a diagnosis. This is a defense mechanism against the threat of cancer and is not always a bad thing. It can help buffer the patient from the tough news and allow them to adjust.

People commonly experience anger during diagnosis/treatment/survivorship. They may feel angry that they have cancer. The underlying basis of anger may be fear and frustration and feeling a lack of control in their life. This can lead to feelings of panic and anxiety. Panic can be as unbearable as physical pain. High levels of anxiety can interfere with healing, pain management and can lead to more physical problems (headaches, pain, sleep disturbances, GI distress and loss of appetite).

Sadness, like fear, is a normal response to the diagnosis of cancer. Similar to the way fear can lead to anxiety, sadness can sometimes evolve into depression. Depression can lead to appetite and sleep disturbance, withdrawal, isolation, feelings of helpless and hopelessness and loneliness and negatively impact a person's quality of life.

Interestingly, many patients may feel guilt. They may feel guilt that they could have done something to prevent their cancer and guilt about being a burden to their family, friends, coworkers and employers. They could also experience the guilt when reflecting on their lives, especially nearing their end of life.

Gratitude, joy, pride, love, happiness and hope can occur simultaneously with the other emotions. Advances in medicine have increased survival rates and thereby increased hope. While few people say they are grateful, many appreciate the influence cancer has had on their lives, to live more fully and in the present. They also may appreciate cancer being a catalyst for personal and relationship growth and change.

**It is important to not judge emotions and allow them to be what they are.**

## **Coping**

Remember, there is no right or wrong emotion. It is important not to judge emotions and allow them to be whatever they are. Some people benefit from talking about their emotions with friends, family, support groups or a professional. Others may benefit from keeping active, learning relaxation strategies, continuing to work or finding daily joy in pleasurable activities. Some people may benefit from professional help to deal with their emotions. Professionals can help individuals through medications, changing unhelpful thought patterns and developing new skills such as mindfulness, imagery, relaxation and deep breathing.

For family and friends of someone facing cancer, a key way to help is to simply **BE THERE**. Allow the cancer patient to express how they are feeling and try not change or fix them. Do not assume, but ask them, what they need. Family and friends also need to attend to their own emotional feelings and find the support that they need.

Sanford Health's Roger Maris Cancer Center has a PsychoOncology team that consists of a Psychologist, Chery Hysjulien, RN, PsyD and two Social Workers, Cheryl Smith, LICSW/MSW and Jacob Byers, LCSW.



# Life after cancer

## Challenges, fears and finding the help to fight them

A colorectal cancer diagnosis brings with it a lot of uncertainty. Will the treatment work? Will I be OK? But those fears don't subside when treatments have ended. Many times new fears are right there to take their place.

"One of the main challenges survivors face is transitioning from active treatment to post-treatment care," says Susan Hofland, a nurse practitioner. "They describe feeling a lack of security in defining a new sense of normal. As active therapy ends, visits are less common, which can leave patients feeling isolated. They naturally fear recurrence."

Nurse navigators are here to help patients address these challenges associated with survivorship. The Survivorship Clinic is designed specifically for those who have been through a cancer diagnosis and treatment,

and is where they can receive individualized education, support and guidance.

"A survivor usually comes in for the first time one to three months after treatment has ended for a rehabilitation plan," says Andrea Mell, a cancer survivorship nurse navigator at Sanford Roger Maris Cancer Center. "The clinic brings awareness to the management of potential late and long-term effects of their treatment and provides them with wellness strategies for overall well-being. They will have access to a number of experts (Advanced Practice Practitioner, dietitian and social worker) who can provide them with supportive resources and management strategies to cope with the effects of their cancer diagnosis."

When patients go through the Survivorship Clinic, they also receive a care plan and

treatment summary. "Patients see multiple medical professionals, undergo several tests, receive various treatments, and all that information can be overwhelming," says Andrea. "With the care plan and treatment summary, the patient is provided with an outline of important information related to their diagnosis and treatment."

This summary includes an individualized plan with evidence-based recommendations for follow-up care, rehabilitation, health maintenance and lifestyle modifications discussed during their clinic visit. This document also serves as a communication tool for the patient's care team, present and future, by providing an ongoing surveillance schedule identifying the role of specific providers.





# Thank you for supporting health, healing and hope

Cancer does not discriminate. It affects people from all ages and walks of life, each with their own personal journey. The medical breakthroughs and inspiring stories featured throughout this report were made possible thanks to the support of people like you.

Whether you donated, participated in an event or volunteered your time to support the Roger Maris Cancer Center, we thank you for believing in us and supporting the highest standard of care for your family and neighbors across the region, right here close to home.

Looking back at the impact we've made in the lives of our patients and families over this past year, by providing resources for patient care, programs, services and research, imagine what we can accomplish moving forward. We hope you will continue to stand with us and help build the future of health care today.



For more information about the Sanford Health Foundation, or to make a gift, please call (701) 234-6246 or email [shfoundation.fargo@sanfordhealth.org](mailto:shfoundation.fargo@sanfordhealth.org).





031000-00112 12/15

**SANFORD<sup>®</sup>**  
**ROGER MARIS**  
**CANCER CENTER**