The Cancer Center Newsletter

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New York Hospital Queens

The Cancer Center

Member NewYork-Presbyterian Healthcare System
Affiliate: Weill Medical College of Cornell University

Screening for Colorectal Cancer

Roger E. Mendis, M.D.
Director of Gastroenterology, NYHQ

March is Colorectal Cancer Awareness Month. Colorectal cancer is the second most common cause of cancer death overall in the United States and is the third most common cause of cancer death when men and women are looked at separately (behind lung, breast and prostate cancers in women and men respectively). The American Cancer Society estimates that there will have been over 145,000 new cases and 56,000 deaths from colorectal cancer in 2005. Overall, the lifetime risk of being diagnosed with colorectal cancer is 5.9% for men and 5.5% for women. In general, colon cancer is a disease of older Americans. The incidence in individuals 60-79 is 50 times greater than those younger than 40. Overall, 91% of cases occur in individuals older than 50. Though much credit must be given to the "Katie Couric Effect" for popularizing the importance of colon cancer screening within the mainstream U.S. population, in point of fact, her late husband who died of metastatic colon cancer in his early forties, would not have routinely undergone screening under current guidelines! Within the population there are considerable ethnic and gender differences. Incidence and mortality rates for colorectal cancer are more than 35% higher in men than in women. African Americans have the highest incidence of colorectal cancer of any racial or ethnic group, and survival from colorectal cancer is lower than in whites. Though colorectal cancer incidence rates in white men and women peaked in 1985, and have declined since, incidence rates have continued to increase in African American men and remained stable in African American women based on data from the SEER Registry. Overall, African Americans as a group were 12.3% more likely to acquire colorectal cancer and 40% more likely to die from it when compared with their white counterparts. In other ethnic groups, incidence rates and mortality rates

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Screening for Colorectal Cancer

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among Asian Americans, Latinos and Native Americans are lower than those among whites. The reasons for higher incidence rates in African Americans are unclear, but a number of factors, including dietary/nutritional habits, sedentary lifestyle, variability in screening rates, lower use of diagnostic testing and increasing smoking rates have been most commonly implicated. An alarming statistic is that the mean age of presentation of colorectal cancer is significantly younger in African Americans. Colorectal cancer occurred before the age of 50 in 10.6% of African American patients compared with 5.5% of whites in one study performed in California. Other studies have shown a proximal shift of adenomas and CRC in African American populations, which may account for the late stage presentation of this malignancy. Based on these findings, the American College of Gastroenterology in March 2005 recommended different screening strategies for African Americans (to follow).

The goal of screening asymptomatic patients is to identify individuals who may have precancerous polyps, and when identified, remove them. Screening tests for colorectal cancer have traditionally consisted of fecal occult blood testing (FOBT), flexible sigmoidoscopy, barium enema, and recently, colonoscopic screening. Fecal occult blood testing is the least sensitive and specific method of screening. Six samples of stool from three consecutive bowel movements are collected by smearing a stool sample on a specially impregnated card. There are two types of FOBTs available: guaiac-based and immunochemical-based tests. Studies have shown a modest (15-33%) reduction in risk of death from CRC in individuals who periodically undergo stool testing. Guaiac-based testing requires avoidance of red meat, NSAIDS and vitamin C for three days. A positive result necessitates colonoscopy. Flexible sigmoidoscopy, which requires minimal preparation and no sedation, allows examination of the left colon for precancerous polyps. The downside of sigmoidoscopy is that it only visualizes approximately one third of the colon, and with the proximal migration of colon cancers over the past 20 years, will miss a large number of right-sided neoplasms. Studies have demonstrated an 80% reduction in distal colon cancers with this screening modality. The combination of a FOBT and sigmoidoscopy is an acceptable option for screening based on the assumption that one test compliments the limitations of the other. Air contrast barium enema involves injection of barium sulfate into the rectum and radiographic images are taken. The limitations of BE include lower sensitivity compared with endoscopic screening tests and need for a second examination (colonoscopy) when a polyp is discovered. Colonoscopy has become the gold standard for screening for colorectal neoplasia. In the National Polyp Study, completed in the early 90's, Sid Winawer, M.D. and his colleagues nicely defined the adenoma-carcinoma sequence and showed us that the time interval from normal mucosa to invasive cancer was many years. Colonoscopic polypectomy was shown to reduce the risk of developing colon cancer. Data from the National Polyp Study suggested this risk reduction to be on the order of 76-90%. Recent data, presented at the 2005 American College of Gastroenterology by Doug Rex, M.D., suggests that this reduction may not be quite that dramatic (on the order of 60%).

Based on current screening options, several groups have offered guidelines for screening average risk individuals. The American Cancer Society and a consortium of experts in digestive diseases (United States Preventive Services Task Force {USPSTF}) have published parallel guidelines which advise that beginning at age 50, both men and women at average risk for colorectal cancer follow one of the following:

- *FOBT or fecal immunochemical test yearly (a single FOBT following digital exam in the doctors' office is not acceptable)*
- *Flexible sigmoidoscopy every 5 years*
- *FOBT plus flexible sigmoidoscopy every 5 years*
- *Double contrast BE every 5 years*
- *Colonoscopy every 10 years*

The American College of Gastroenterology guidelines are similar to the ACS, with the main difference being their strong disagreement with barium enema as an effective tool for CRC screening. This is based on lack of published data on double contrast barium enema in screening populations.

In March 2005 recent data on the higher risk of African Americans for colorectal cancer led the ACG to recommend screening beginning at the age of 45 in this population, and because of the proximal predominance of lesions, be done by colonoscopy, not sigmoidoscopy. Other individuals in whom we routinely recommend screening at an earlier age are those with a first-degree relative with colon cancer or polyps. Though the recommendations vary depending on the age of the affected family member, in general, this should begin 10 years before the age of diagnosis of the affected family member, or no later than age 40. High-risk groups that require special attention are those with HNPCC (Hereditary Non-Polyposis Colorectal Cancer) or Lynch Syndrome. These individuals, who make up a small minority of patients with colorectal cancer (<5%), have an earlier onset of cancer, proximal distribution of tumors and a tendency for cancers to arise from flat mucosa. Recognition of this entity by careful family history is essential, and should be thought of in individuals with family clusters of colon cancers, urogenital or gynecological malignancies occurring before the age of 50 (as defined by the Amsterdam and Bethesda criteria). These individuals should undergo screening colonoscopy beginning at age 25 and every 1-2 years thereafter. Germ-line mutations in the mismatch repair genes lead to the development of HNPCC. Routine immunohistochemical testing is now available and may be useful in screening family probands in order to detect affected family members.

Newer technologies with future promise for colorectal cancer screening include fecal DNA testing and "virtual" colonoscopy (CT or MR colonography). Virtual colonoscopy involves the 3-D reconstruction of 2-D images obtained by CT scan or MRI. Though commercially available, the test is not recommended by any of the major organizations for screening because of concerns of insensitivity for smaller lesions and inconsistencies in the level of performance. With improvements in technique and overall quality this may become a viable alternative to standard endoscopic screening. Fecal DNA is an exciting non-invasive test that takes advantage of the fact that epithelial cells (both benign and neoplastic) are continuously shed in the fecal stream. These cells can be concentrated and various markers of dysplasia identified. Recent studies have yet to demonstrate adequate sensitivity for adenomas or frank malignancies to warrant its use in routine screening in 2006.

In summary, colorectal cancer is a slow growing malignancy that is readily treatable in the early stages. Newly diagnosed cases often represent missed screening opportunities on the part of the health care provider or patient. There are a number of screening options available, with colonoscopy rapidly becoming the gold standard. However, no matter which option physician and patient decide on, the most important thing to remember is that colorectal cancer screening saves lives!

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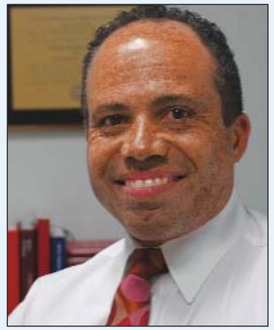
Roger E. Mendis, M.D.



Roger E. Mendis, M.D.

Roger Mendis, M.D., is the Director of Gastroenterology, a division in the Department of Medicine at New York Hospital Queens (NYHQ). He is also Director of the Hospital's Gastroenterology Fellowship program and oversees the busy Gastrointestinal Endoscopy Unit. Before coming to NYHQ, Dr. Mendis was the Director of the Gastroenterology Fellowship Program at Long Island College Hospital in Brooklyn, and was a Clinical Assistant Professor of Medicine at SUNY Downstate.

Dr. Mendis earned his undergraduate degree from Brown University and his medical degree from the Tufts University School of Medicine in Boston. He served his residency in Internal Medicine at the Cornell Campus of NewYork-Presbyterian Hospital.

Dr. Mendis completed his fellowship in Gastroenterology and Therapeutic Gastrointestinal Endoscopy at Memorial Sloan-Kettering Cancer Center. He is board-certified in Internal Medicine and Gastroenterology. He is a Fellow of the American College of Gastroenterology and member of several medical societies, which include the Crohn's and Colitis Foundation of America, the American Society for Gastrointestinal Endoscopy and the American Gastroenterological Association.

He has conducted extensive research, written numerous abstracts and articles and has presented his findings throughout the country. His interest is in gastrointestinal cancer and the use of advanced endoscopic procedures in its diagnosis and management. He has been a speaker on colorectal cancer screening.

Dr. Mendis is fluent in Spanish and conversant in Portuguese and French.

Digital Mammography Versus Film Mammography for Breast Cancer Screening

Several studies have supported reduction of breast cancer mortality with regular screening mammograms. A trial of seven counties in Sweden demonstrated a decrease of 44% in death rates after a national screening program had been in effect for 10 years. A meta-analyses of eight randomized trials demonstrated a 16-35% decrease in breast cancer mortality after 14 years of observation in women 50-69 years of age assigned to screening mammography versus the control group.[1] There was a 15-20% decrease in breast cancer mortality in women between the ages of 40-49, but these results were not evident until 11 years after the start of programs. The lesser benefit in the younger age group may be attributed to increased breast density, lower incidence of breast cancers, and more aggressive tumors.[2] Overall, these numbers may be even greater because of improved technological advances in mammography after these studies were done and the current yearly recommended interval is shorter than the intervals in some of the studies.

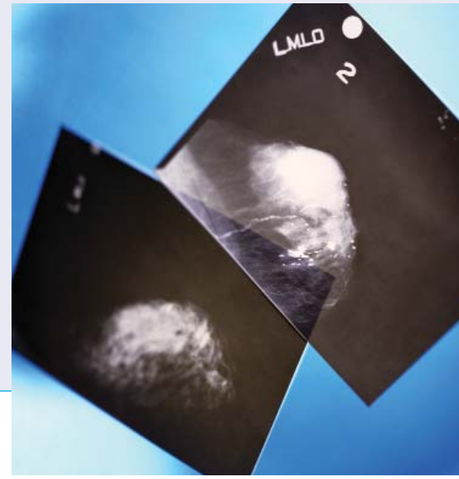
The American Cancer Society, the American College of Radiology, the National Comprehensive Cancer Network and the American Medical Women's Association recommend that women over 40 years of age be offered annual screening mammography. Due to the limited studies on screening mammograms in women >74 years of age, there is no general consensus beyond this age. If the woman is healthy with minimal co-morbidities, screening should be continued. According to the Cancer Genetics Studies Consortium, women with BRCA1 or BRCA2 mutations should be screened annually by mammography and biannually with clinical breast examinations beginning at 25-35 years of age. Women with a significant family history of breast cancer should be screened starting at age 10 years younger than the affected first-degree relative.

The first FDA approved digital mammography system was introduced in 2000. The image is recorded electronically and stored in a computer, it is projected onto the screen and hard copies (films) can be made. The use of digital mammography is becoming more widespread but currently only 8% of all facilities in the United States have this system. The advantages of digital mammography over conventional film mammography include the ability to manipulate the contrast and image on screen (thus improving ability to visualize dense areas), faster image acquisition, half the exam time of film-based mammography, easier retrieval and storage of images, and teleradiology (ability to send images via phone lines and networks). The disadvantage is the high cost of the system: $175,000-500,000, which is 1.5-4 times greater than conventional film mammography machines.

The diagnostic accuracy of digital mammography versus film mammography was addressed in a recent landmark study that was published in the October 27, 2005 issue of the New England Journal of Medicine.[3] The Digital Mammographic Imaging Screening Trial (DMIST) enrolled 42,760 women who were screened with both digital and film mammography. The pictures were interpreted independently by two radiologists. Results of the study demonstrated that digital mammography was more accurate in:

1. *Women under the age of 50 years*
2. *Women with radiographically dense breasts (approximately 40% of women undergoing screening mammography)*
3. *Pre- or peri-menopausal women of any age.*

Although mammography is currently the best modality we have available for breast cancer screening, it is not without limitations. It is important to remember that approximately 10% of all breast cancers, especially lobular carcinoma, are not seen on mammography.



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Margaret Cawley, M.S., R.N., A.N.P., A.O.C.N.

Margaret Cawley, M.S., R.N., A.N.P., A.O.C.N., Oncology Clinical Nurse Specialist/Adult Nurse Practitioner, has been in her position at NYHQ since 1986. She received her certification as an Oncology Certified Nurse in 1988 and as an Advanced Oncology Certified Nurse in 1998. She has received numerous awards and honors, including the Wholeness of Life Award from the Healthcare Chaplaincy, the Ortho Biotech Quality of Life Award from the Tri State Oncology Nursing Society Chapters, the Excellence in Patient/Public Education Award from the Oncology Nursing Society and the Award for Excellence from the American Cancer Society (ACS), Queens Division.

Ms. Cawley's memberships include the Oncology Nursing Society and the ACS, Queens Division. She is a past member of the Board of the Directors of the American Cancer Society, Queens Division. She is an adjunct professor and a preceptor at several universities, and has had several articles published.

Margaret Cawley, M.S., R.N., A.N.P., A.O.C.N.

Tumor Boards/Grand Rounds/Symposia

The Department of Radiation Oncology has **New Patient Conference** every Tuesday morning at 8 a.m.

Breast Tumor Board is held on the second and fourth Wednesday of every month from 12 noon to 1 p.m. Lunch is served. Some upcoming dates are April 12th and 26th and May 10th and 24th.

Thoracic Tumor Board is on the third Wednesday of every month from 9 a.m. to 10 a.m. Some upcoming dates are April 19th and May 17th.

Gyn Tumor Board is held on the first Wednesday of every month from 8 a.m. to 9 a.m. Some upcoming dates are April 5th and May 3rd.

General Tumor Board is held every Tuesday from 4 p.m. to 5 p.m.

There is one CME credit awarded per each Tumor Board meeting attended. All the above noted educational programs are held in the **Anerena M. Anextis Conference Room** in the Department of Radiation Oncology. Refreshments are served.

The Cancer Center, as part of the Medical Oncology Lecture Series, will hold a program at Café on the Green on March 15, 2006. The subject will be **"Ovarian Cancer Update."** The guest speaker is **Robert F. Ozols, M.D.**, Professor of Medicine, Temple University; Senior Vice President, Medical Science, Fox Chase Cancer Center; Medical Director, Hospital of the Fox Chase Cancer Center.

Recent Events

Akkamma Ravi, M.D., Attending Physician in Radiation Oncology at NYHQ and Assistant Professor of Radiology at Cornell, has been reappointed to the Radiation Oncology Committee of the American Association of Women Radiologists. Committee members consist of leaders in the field of Radiation Oncology from major Radiation Oncology centers throughout the country.

Susan H. Lee, M.D., Attending Physician in the Breast Center, and Assistant Professor of Surgery in Clinical Obstetrics and Gynecology at Cornell was a guest speaker at the Korean American Medical Association Annual Meeting. Her topic was "**Update on Breast Cancer**." Dr. Lee has also been appointed the Liaison Physician to the Cancer Commission of the American College of Surgeons for NYHQ.

Roger Mendis, M.D., Director, Gastroenterology presented at Grand Rounds at Parkway Hospital on Oct. 20th and at Mary Immaculate Hospital on Nov. 11th. The subject was "**Colon Cancer 2005**." He also was a guest on a local radio program in December discussing "**Colon Cancer Screening**."

The Cancer Center presented a symposium on **"Early Stage Lung Cancer"** on Oct. 25th, 2005 at the Theresa and Eugene M. Lang Center for Research and Education at NYHQ. The speakers were **Paul C. Lee, M.D.**, Assistant Professor of Cardiothoracic Surgery Weill Medical College of Cornell University, Director, Thoracic Surgery New York Hospital Queens; **Stephen R. Karbowitz, M.D.**, Clinical Assistant Professor Weill Medical College of Cornell University, Director, Division of Pulmonary Medicine New York Hospital Queens; **Dattatreyudu Nori, M.D., F.A.C.R., F.A.C.R.O.**, Professor and Chairman Department of Radiation Oncology Weill Medical College of Cornell University NewYork-Presbyterian Hospital, Director, Cancer Center New York Hospital Queens; **Roger Kresztes, M.D.**, Assistant Professor of Clinical Medicine Weill Medical College of Cornell University, Assistant Attending Physician NewYork-Presbyterian Cornell; **Jac D. Scheiner, M.D.**, Board Certified in Diagnostic Radiology and Nuclear Medicine, Attending Radiologist New York Hospital Queens; **Stephen B. Solomon, M.D.**, Associate Professor, Department of Radiology, Division of Interventional Radiology Memorial Sloan-Kettering Cancer Center; **David F. Yankelevitz, M.D.**, Professor of Radiology Weill Medical College of Cornell University, Attending Radiologist NewYork-Presbyterian Cornell.

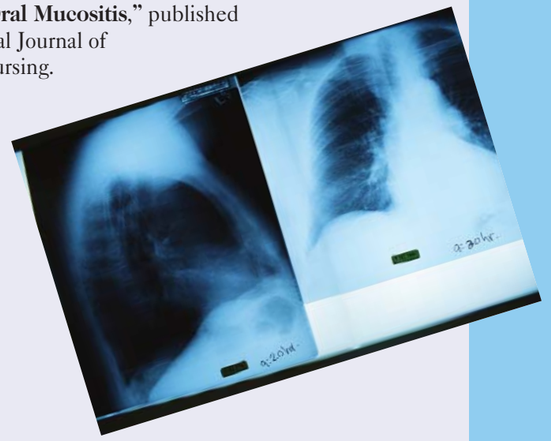
The Cancer Center presented a symposium on **"New Developments in the Management of Head and Neck Cancer"** on Dec. 2nd, 2005 at the Theresa and Eugene M. Lang Center for Research and Education at NYHQ. The speakers were **Dattatreyudu Nori, M.D., F.A.C.R., F.A.C.R.O.**, Professor and Chairman, Department of Radiation Oncology, Weill Medical College of Cornell University, NewYork-Presbyterian Hospital, Director, Cancer Center, New York Hospital Queens; **Brij M. Sood, M.D.**, Associate Professor, Division of Radiation Oncology, Weill Medical College of Cornell University, Attending, Radiation Oncology New York Hospital Queens; **Larry Shemen, M.D.**, Assistant Clinical Professor of Otorhinolaryngology Weill Medical College of Cornell University, Chief, Head and Neck Service New York Hospital Queens; **Jerry Huo, M.D.**, Clinical Assistant Professor of Otorhinolaryngology Weill Medical College of Cornell University, Director of Otorlaryngology New York Hospital Queens; **Tu Tu Aung, M.D.**, Clinical Assistant Professor of Medicine Weill Medical College of Cornell University, Attending Oncologist, Department of Medicine New York Hospital Queens; **John F. Carew, M.D.**, Assistant Professor Department of Otorhinolaryngology, Head and Neck Surgery Weill Medical College of Cornell University; **Margaret Cawley, M.S., R.N., A.N.P., A.O.C.N.**, Oncology Nurse Practitioner New York Hospital Queens; **Engracio P. Cortes, M.D., F.A.C.P.**, Clinical Associate Professor of Medicine Weill Medical College of Cornell University, Director, Oncology Research New York Hospital Queens; **Barry H. Kaplan, M.D.**, Clinical Associate Professor of Medicine Weill Medical College of Cornell University, Director, Division of Medical Oncology New York Hospital Queens; **Stanley Kerpel, D.D.S.**, Diplomate, American Board of Oral and Maxillofacial Pathology, Associate Director, Section of Oral Pathology Department of Dental Medicine New York Hospital Queens, Associate Director, Oral Pathology Laboratory, Inc.; **Jeffrey Chun-Suk Lee, M.D.**, Clinical Assistant Professor of Radiology Weill Medical College of Cornell University, Director of Neuoradiology and MRI New York Hospital Queens; **Jack A. Pasquale, M.D.**, Physician-in-Charge of Cancer Nutrition, Physician Nutrition Specialist/Consultant New York Hospital Queens; **Daisy Saw, M.D.**, Clinical Associate Professor of Pathology Weill Medical College of Cornell University, Chairman, Department of Pathology New York Hospital Queens; **Ira M. Sturman, D.D.S.**, Associate Clinical Professor Albert Einstein College of Medicine, Oral and Maxillofacial Surgery New York Hospital Queens; **Kathleen Patricia Woods, Ph.D., C.A.S.A.C., C.E.A.P.**, Adjunct Professor, Queens College, Director for Consult/Liaison Services, Chief Learning Officer for Corporate College New York Hospital Queens.

The Cancer Center, as part of the Medical Oncology Lecture Series, held a program at Café on the Green on Nov. 11th, 2005. The subject was **"Update on Colorectal Cancer."** The speaker was **John Marshall, M.D.**, Associate Professor, Departments of Medicine and Oncology, Director of Developmental Therapeutics and GI Oncology, Associate Director of Clinical Research, Lombardi Cancer Center, Georgetown University.

The Department of Radiation Oncology Grand Rounds on Feb. 10th, 2006 at NewYork-Presbyterian Hospital was on **"Ameliorating Toxicities Associated with Treatment of Non-Small Cell Lung Cancer."** The discussion was led by **Ritsuko Komaki, M.D., F.A.C.R.**, Professor of Radiation Oncology University of Texas MD Anderson Cancer Center.

Lincoln K. Pao, M.D., Attending Physician in Radiation Oncology at NYHQ and Assistant Professor of Radiology at Cornell has been appointed as the President of the New York Roentgen Society, Radiation Oncology Section. Dr. Pao also recently gave a presentation on Brachytherapy at the monthly meeting at the New York Academy of Medicine.

Margaret Cawley, M.S., R.N., A.N.P., A.O.C.N., Oncology Clinical Nurse Specialist/Adult Nurse Practitioner, recently co-authored an article on **"Current Trends in Managing Oral Mucositis**," published in the Clinical Journal of Oncology Nursing.



Cancer Center Clinical Program Leadership

Director	
Dattatreyudu Nori, M.D., F.A.C.R., F.A.C.R.O.	670-1501
Breast Center	
Karen Karsif, M.D.	670-1185
Susan Lee, M.D.	
Colorectal Surgery	
Howard Tiszenkel, M.D.	445-0220
Gastrointestinal, Medical	
Roger Mendis, M.D.	670-2559
Gastrointestinal, Surgical	
Kenneth Rifkind, M.D.	445-0220
Gynecologic Oncology	
Marie Welshinger, M.D.	670-1170
Manolis Tsatsas, M.D.	
Head and Neck Oncology	
Jerry Huo, M.D.	670-0006
Medical Oncology	
Barry Kaplan, M.D., Ph.D.	460-2300
Neurosurgery	
Mitchell Levine, M.D.	670-1572
Pulmonary Medicine	
Stephen Karbowitz, M.D.	670-1405
Radiation Oncology	
Dattatreyudu Nori, M.D.	670-1501
Radiology	
William Wolff, M.D.	670-1594
Surgical Oncology	
Simon Fink, M.D.	670-1120
Surgical Pathology	
Daisy Saw, M.D.	670-1141
Stanley Kerpel, D.D.S. *(Oral Pathology)*	670-1520
Thoracic Surgery	
Paul Lee, M.D.	670-2707
Urology	
Albert Tarasuk, M.D.	353-3710
Genetic Counseling	
Brenda Zak	670-2110
Nutrition	
Jack Pasquale, M.D.	465-0041
Mary Grace Sucholet, R.D.	670-2550
Pain Management	
Peter Silverberg, M.D.	670-1080
Margaret Cawley, R.N.	670-1422
Social Service	
Marlene Smike	670-1300
Cancer Research	
Engracio Cortes, M.D.	279-9101
Brij M. Sood, M.D.	670-1501
Chu-Cheng Kan, Ph.D.	670-1724
Administration	
Tom Deutsch, M.P.H., M.B.A., Administrative Director	670-1501
Vijaya Malladi, C.T.R., Manager	670-1379

Susan H. Lee, M.D.

Susan H. Lee, M.D.

Susan H. Lee, M.D., is an Attending Physician in the Department of Surgery at New York Hospital Queens. She is a full time physician at the NYHQ Breast Center, which is directed by Dr. Karen Karsif. Dr. Lee completed a Fellowship in Breast Disease/Surgery as a Susan G. Komen Fellow at The Breast Health Center of the Brown University School of Medicine. She trained for two years in general surgery and completed a residency in Obstetrics and Gynecology at the Mayo Graduate School of Medicine. She received her medical degree from the University of Illinois College of Medicine and her Bachelor of Science degree from the University of Illinois.

Dr. Lee is Board Certified in Obstetrics and Gynecology and is a Fellow of both the American College of Surgeons and the American College of Obstetrics and Gynecology. She is an Assistant Professor of Surgery in Clinical Obstetrics and Gynecology at Weill Medical College of Cornell University.

Dr. Lee is a member of numerous organizations and committees involved in the diagnosis and treatment of breast cancer. These include the New York Hospital Queens Institutional Review Board, the Healthcare Association of New York State's Breast Center Demonstration Project Advisory Board, the American College of Surgeons Oncology Group Special Populations Committee and the American Cancer Society Korean Division Advisory Board. She is also the NYHQ Liaison Physician to the Commission on Cancer of the American College of Surgeons.

Dr. Lee has been involved in several clinical research projects and has published numerous articles and has spoken widely on the subject of Breast Cancer.

Dr. Lee is conversant in Korean.

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