

# THE CANCER CENTER *Newsletter*

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New York Hospital Queens (NYHQ)

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## *Inside This Issue:*

INTRAPERITONEAL  
CHEMOTHERAPY IN  
THE MANAGEMENT  
OF OVARIAN CANCER

*Page 2*

CONTROLLING PAIN IN  
CANCER PATIENTS

*Page 2*

INTRAPERITONEAL  
THERAPY FOR OVARIAN  
CANCER

*Page 3*

BIOGRAPHY:  
VIKAS VARMA, M.D.

*Page 3*

RECENT EVENTS

*Page 4*

PATIENT SUPPORT GROUPS

*Page 4*

CLINICAL PROGRAM  
LEADERSHIP

*Page 4*

LAPAROSCOPIC  
COLECTOMY FOR CANCER  
*continued*

*Page 5*

BIOGRAPHY: HOWARD I.  
TISZENKEL, M.D.

*Page 5*

SAVE THE DATES,  
UPCOMING SYMPOSIA

*Page 5*

FEEDBACK FROM  
OUR PATIENTS

*Back Page*

TUMOR BOARDS/PATIENT  
CARE CONFERENCES

*Back Page*

New  
York  
Hospital  
Queens



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

## LAPAROSCOPIC COLECTOMY FOR CANCER

By Howard I. Tiszenkel, M.D.  
Director, Colon and Rectal Surgery, NYHQ

Laparoscopy is one of the most important surgical advances over the last 50 years. It is used for many indications including gallbladder surgery, appendectomy, hernia repair, bariatric surgery, and removal of many organs (e.g. spleen, adrenal gland, stomach and pancreas). In the early 1990's Moises Jacob did the first laparoscopic colectomy and many others soon followed. The early experience with laparoscopic colon cancer surgery was not good. There were over 30 case reports of port site cancer recurrence with an incidence up to 21%. This was a complication that was rarely seen after open colectomy for colon cancer (<1%). The academic community placed a moratorium on laparoscopic colon cancer surgery until a national registry and randomized controlled clinical trials would answer the questions of safety and efficacy. We all knew the operation could be performed, but should it be done?

There are at least 25 randomized controlled trials which have looked at short term advantages of laparoscopic colectomy. These trials show less blood loss, less pain, shorter post-operative ileus, improved pulmonary function, and overall lower morbidity. A Cochrane Review in 2006 shows no difference in morbidity or mortality. This suggests short term benefits, and likely advantages.

The next question concerns oncologic benefits. Many surrogate endpoints have been evaluated. Cell mediated immunity is better maintained after laparoscopic colectomy. Interleukin-6 levels are lower after laparoscopy. Studies also confirm less blood loss and transfusions. This allows the immune system to be less suppressed. These three advantages of laparoscopic colectomy all supported the need for the clinical trials.

The first multi-center clinical trial for colon cancer reported was the COLOR trial from Europe. This showed less blood loss, fewer analgesics used, shorter ileus, and shorter length of stay. The lymph nodes removed and the surgical margins were the same, with the 30 day morbidity and mortality also the same.

*continued on page 5*

# THE ADMINISTRATION OF INTRAPERITONEAL CHEMOTHERAPY IN THE MANAGEMENT OF OVARIAN CANCER, *A Nursing Prospective*

By Margaret M. Cawley, MSN, RN, ANP, AOCN, *Oncology Clinical Nurse Specialist, NYHQ*

In January 2006, the National Cancer Institute (NCI) issued a clinical announcement stating that women with optimal debulked stage III ovarian cancer can now be offered a regimen combining intravenous (IV) chemotherapy and intraperitoneal (IP) chemotherapy.

On 6 North at NYHQ this protocol is now being implemented. After receiving 24 hours of Taxol intravenously patients receive hydration IV for 1-2 hours as well as an antiemetic regime. The patient is requested to void and then is placed in a semi-flowers position. The abdominal Infusaport is accessed using sterile technique with a Huber Safety Needle and the port is flushed

with sterile saline and a sterile dressing applied. Depending on the patient peritoneal fluid may or may not be aspirated from the port. The 2 liter chemotherapy bag is attached and infused via gravity, not by an infusion pump.

The chemotherapy is administered at room temperature so that the patient will experience minimized abdominal cramping. The chemotherapy is usually completed in 2 hours, and the Infusaport needle removed. During the infusion the patient is assessed for abdominal pain secondary to increased abdominal girth. The Huber needle is also checked to ensure it is properly secured in place. Additional IV hydration is given for 1-2 hours post chemotherapy, and the patient is instructed to turn from side to side every 15 minutes for one hour to help

distribute the intraperitoneal chemotherapy.

The patient may be discharged later the same day with instructions regarding their antiemetic regime and which symptoms should lead them to call their oncologist, such as fever, abdominal pain, nausea/vomiting. The patient is educated in the management of potential side effects and the strategies to manage them.

Guidelines for the administration of Intraperitoneal Chemotherapy have been written for the nursing staff. As patients are admitted to 6 North the Clinical Nurse Specialist certifies the nurse in their competency to administer the IP chemotherapy. The patient's oncologist follows the patient and on the eighth day IP chemotherapy is administered on an outpatient basis or the patient is readmitted to 6 North.

## CONTROLLING PAIN IN CANCER PATIENTS

By Vikas Varma, M.D.  
*Director of Chronic Pain Management, NYHQ*

Pain is everywhere, suffering is optional.

Interventional pain management represents a major advance in the management of cancer and non-cancer pain and adds a new dimension to opioid and non-opioid therapy by allowing prolonged analgesia and effective pain management. It has therefore gained immediate and widespread popularity in the management of both cancer as well as postoperative pain. Although interventional pain management has been traditionally used for a long time for pain management, recent advances in fluoroscopy-guided nerve block injections and other advanced spinal techniques have added a new dimension, especially for relief of immediate postoperative pain.

Cancer-related pain and some other nonmalignant pain and neuropathic pain syndromes may require the use of both interventional and non-interventional pain management techniques, as well as require continuous fine tuning of pain management techniques and drug dosages to ensure optimal pain relief. Assessment pain evaluation using scales may include VAS (visual analog scale), frequently used in pain research or pain evaluation. The medical management of intractable pain should

follow the World Health Organization ladder for cancer pain relief, using continuous pain assessment and aggressive treatment of side effects to optimize therapy.

Prior to consultation for interventional pain management procedures, the patient suffering from cancer-related pain should be treated aggressively with standard therapies and optimization of systemic opioid therapy utilizing sustained release morphine preparations, methadone, OxyContin, and Fentanyl transdermal patch. Intervenous and subcutaneous infusions with patient-controlled analgesia capability are also appropriate modalities in the initial management of cancer-related pain. The patient receiving traditional opioid therapy who either does not achieve analgesia or experiences side effects that do not respond to appropriate treatment may require more invasive analgesic techniques.

The consideration for invasive techniques should be carefully and thoughtfully analyzed prior to the implementation. The practice of interventional pain management including fluoroscopy-guided nerve blocks begins with appropriate patient and procedure selection. The choice of the fluoroscopy-guided procedure is made on the basis of many factors, including the expected duration of therapy, pain source, and the planned therapy, as well as the

desired outcome. Both nerve block injections, as well as advanced neuromodulation techniques, especially spinal cord stimulation and morphine pumps, have their distinct advantages as well as disadvantages. The nerve block injections used in pain management may be as simple as the placement of a temporary catheter or a nerve block injection needle. This may be done by the bedside or it may be a complicated advanced procedure done in a surgical center setting. The importance of appropriate patient and procedure selection, as well as mastery of the technical aspects of the nerve block procedure cannot be overstated. Ongoing management of patients after the procedure is equally important, also leading to the education of the patient, the family, and the healthcare staff involved.

Drug administration is also paramount to the long term success of cancer pain management. Close patient follow-up with frequent reassessment and timely dose and drug adjustments is equally essential. Henceforth, strong outpatient clinic and home care components to the cancer pain management program help to ensure good and desired outcomes. Further information on cancer pain and advanced neuromodulation techniques can be obtained from various websites, including [medtronic.com](http://medtronic.com) and [spinehealth.com](http://spinehealth.com).

# INTRAPERITONEAL THERAPY FOR OVARIAN CANCER

By Marie Welshinger, M.D.  
Director, Gynecologic Oncology, NYHQ

Epithelial ovarian cancer is the leading cause of death among the gynecologic cancers and the fourth leading cause of cancer death in women in the United States. It is estimated that in 2006 approximately 20,180 new cases and 15,310 ovarian cancer deaths will occur in the U.S.<sup>1</sup> The overall incidence of ovarian cancer has remained constant for the last three decades. The overall survival has improved since 1974, from 38% to 44%, which is statistically significant.<sup>2</sup>

The current standard of care requires comprehensive staging of early stage ovarian cancer, aggressive debulking (cytoreduction) of advanced disease, and combination chemotherapy using platinum and paclitaxel. Five randomized studies comparing intraperitoneal (IP) with intravenous (IV) chemotherapy for adjuvant treatment of stage III disease after initial surgery were published between 1996 and 2001.<sup>3,4,5,6,7</sup> At the 2005 American Society of Clinical Oncology

(ASCO) meeting, Dr. Armstrong presented survival data from a Gynecologic Oncology Group study (GOG 172) evaluating IV cisplatin and IV paclitaxel vs IP cisplatin and IP paclitaxel plus IV paclitaxel.<sup>8</sup> The control group (n=210) received IV paclitaxel (135mg/m<sup>2</sup>) over 24 hours on day 1 and received IV cisplatin (75mg/m<sup>2</sup>) on day 2. The experimental group received IV paclitaxel (135mg/m<sup>2</sup>) over 24 hours on day 1 and received IP cisplatin (100mg/m<sup>2</sup>) on day 2 followed by IP paclitaxel (50mg/m<sup>2</sup>) on day 8. Despite the fact that only 42% of patients in the experimental (IP) arm completed the intended 6 cycles of therapy and 48% received < 3 cycles, a survival advantage of 16 months was seen (overall survival =64.6 vs 49.7 months, p=0.0076). The IP-therapy group experienced greater toxicity and even reported worse quality of life (QOL) during treatment than the IV-therapy group. However, no QOL differences were observed one year after treatment. The compelling results of this study, as well as others listed, translate into the re-emergence of IP chemotherapy as a likely standard in primary

treatment of ovarian carcinoma.<sup>8</sup>

On January 5, 2006, the National Cancer Institute issued an announcement "encouraging treatment with anticancer drugs via two methods" after surgery for women with advanced ovarian cancer. The website goes on to explain in lay-terms "the combined methods, which deliver drugs into a vein and directly into the abdomen, extend overall survival for women with advanced ovarian cancer by about a year" (<http://ctep.cancer.gov/highlights/ovarian.html>). The Gynecologic Oncology service at New York Hospital Queens is experienced with selection of appropriate patients and placement of the intraperitoneal catheter. In cooperation with Medical Oncology, several patients have begun intraperitoneal treatment. We anticipate that these women experience improvement in survival while we carefully monitor for the expected greater toxicity. We await further studies aimed at reducing toxicity while maintaining the survival benefit associated with IP therapy for patients with optimally debulked advanced ovarian cancer.

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3. Alberts DS, Liu PY, et al. *Intraperitoneal cisplatin plus intravenous cyclophosphamide versus intravenous cisplatin plus intravenous cyclophosphamide for stage III ovarian cancer*. *N Engl J Med* 1996;335:1950-5.

4. Polyzos A, Tsacaris N, et al. *A comparative study of intraperitoneal carboplatin versus intravenous carboplatin with intravenous cyclophosphamide in both arms as initial chemotherapy for stage III ovarian cancer*. *Oncology* 1999;56:291-6.

5. Yen MS, Juyang CM, et al. *Intraperitoneal cisplatin-based chemotherapy vs intravenous cisplatin-based chemotherapy for stage III optimally cytoreduced epithelial ovarian cancer*. *Int J Gynaecol Obstet* 2001;72:55-60.

6. Gadducci A, Carnino F, et al. *Intraperitoneal versus intravenous cisplatin in combination with intravenous cyclophosphamide and epi-doxorubicin in optimally cytoreduced advanced epithelial ovarian cancer: a randomized trial of the Gruppo Oncologico Nord-Ovest*. *Gynecol Oncol* 2000;76:157-62.

7. Markman M, Bundy BN, et al. *Phase III trial of standard-dose intravenous cisplatin plus paclitaxel and intraperitoneal cisplatin in small-volume stage III ovarian carcinoma: and intergroup study of the Gynecologic Oncology Group, Southwestern Oncology Group, and Eastern Cooperative Oncology Group*. *J Clin Oncol* 2001;19:1001-7.

8. Armstrong DK, Bundy B, et al. *Intraperitoneal cisplatin and paclitaxel in ovarian cancer*. *N Engl J Med*;354:34-43.

## VIKAS VARMA, M.D.

Vikas Varma, M.D. is the newly appointed Director of Chronic Pain Management at New York Hospital Queens. He is a Pain Management Specialist who is a Diplomate of the American Board of Pain Medicine and Pain Management, a Diplomate of the American Board of Neurology and a Diplomate of the American Board of Electrodiagnostic Medicine.

Before joining the staff at NYHQ, Dr. Varma was on the faculty at North Shore University Hospital, Manhasset. He completed a Fellowship in Interventional Pain Management at the University of South Florida, Moffitt Cancer Center.

He also completed a fellowship in Electromyography (EMG) and Neuromuscular Diseases at North Shore University Hospital. Dr. Varma completed his residency in Neurology at Mt. Sinai Medical Center in New York.

Dr. Varma is a member of several societies, including the International Spinal Injection Society, the American Society of Interventional Pain Physicians and the American Society of Neuroimaging.

His office is located at 164-08 65th Ave. in Fresh Meadows and his office number is 718-460-1111.



Vikas Varma, M.D.

## RECENT EVENTS

**Dattatreyyudu Nori, MD, F.A.C.R.**, Director of the Cancer Center and Professor & Chairman, Radiation Oncology at NYHQ and New York Presbyterian, Weill Medical College of Cornell University was selected one of the top cancer physicians in a survey conducted by Castle Connolly Medical Ltd. More than 100,000 leading cancer doctors were contacted to get the results of this survey.

**Engracio Cortes, M.D.** Attending Medical Oncologist at NYHQ and Clinical Associate Professor of Medicine at Weill Medical College of Cornell University sponsored a **National Cancer Survivor's Day Celebration** for his patients on June 8th. Approximately 50 patients, both newly diagnosed and long-term survivors came to the event. Some had their cancers first diagnosed by Dr. Cortes 20 years ago.

**Akkamma Ravi, M.D.**, Attending Radiation Oncologist and Assistant Professor of Radiology at Cornell, is the Principal Investigator of a study being conducted at NYHQ of **"Treatment Patterns and Outcomes of Elderly Breast Cancer Patients Age 75 and Older"**.

**Daisy Saw, M.D.**, Chairman of Pathology and Laboratories, and Clinical Associate Professor of Pathology at Weill Medical College of Cornell University received an award on behalf of NYHQ, for its service to the community, from the **Chinese Unit of the American Cancer Society**. Dr. Saw was also recently reappointed as a board member of the **American Cancer Society-Asian Initiatives** program.

The Cancer Center, as part of the Medical Oncology Lecture Series, held a program at Café on the Green on June 28, 2006. The subject was **"ASCO Update"**. The speaker was **Barry H. Kaplan, M.D., Ph.D.**, Director of Medical Oncology at NYHQ, President of Queens Medical Associates, and Clinical Associate Professor of Medicine at Weill Medical College of Cornell University.

The Department of Radiation Oncology grand rounds on June 8th, 2006 was on one of the latest advances in radiation treatment. The program, **"Implementation of Image Guided Radiation Therapy (IGRT)"**, was presented by **Todd Scarborough, M.D.**, Medical Director, MIMA Cancer Center, Associate Professor, Department of Radiation Medicine, Oregon Health and Science University.

**Nandanuri Reddy, Ph.D.**, Associate Director, Physics in the Department of Radiation Oncology at NYHQ presented his paper on **"The Potential for Dose Dumping in Normal Tissues with IMRT"** at the 48th Annual Meeting of the American Association of Physicists in Medicine.

## PATIENT SUPPORT GROUPS

The American Cancer Society sponsors a **"Man-to-Man"** program for **prostate cancer** patients, which is held on the second Wednesday of every month from 6 p.m. to 7:30 p.m.

The American Cancer Society sponsors a **"Look Good-Feel Better"** program for **female cancer patients undergoing Chemotherapy and Radiation Therapy** on the second Monday of every month from 5:30 p.m. to 6:30 p.m.

The above two programs are held in the Anerena M. Anextis Conference Room in the Department of Radiation Oncology at NYHQ. To register, please call 1-800-ACS-2345.

Margaret Cawley, M.S., R.N., A.N.P., A.O.C.N. conducts a program for **"Newly Diagnosed Women with Breast Cancer"** at Dr. Tu Tu Aung's office located at 200-20 44th Ave. in Bayside on the first Thursday of each month. Pre-registration is required at 718-279-9456. Also in Dr. Aung's office, there is a support group for **"Women with Newly Diagnosed Ovarian Cancer"** on the first Tuesday of every month. Pre-registration at the same number is required.

## CANCER CENTER CLINICAL PROGRAM LEADERSHIP

<b>DIRECTOR</b> Dattatreyyudu Nori, M.D., F.A.C.R., F.A.C.R.O.	670-1501
<b>BREAST CENTER</b> Karen Karsif, M.D. Susan Lee, M.D.	670-1185
<b>COLORECTAL SURGERY</b> Howard Tiszenkel, M.D.	445-0220
<b>GASTROINTESTINAL, MEDICAL</b> Roger Mendis, M.D.	670-2559
<b>GASTROINTESTINAL, SURGICAL</b> Kenneth Rifkind, M.D.	445-0220
<b>GYNECOLOGIC ONCOLOGY</b> Marie Welshinger, M.D. Manolis Tsatsas, M.D.	670-1170
<b>HEAD AND NECK ONCOLOGY</b> Jerry Huo, M.D.	670-0006
<b>MEDICAL ONCOLOGY</b> Barry Kaplan, M.D., Ph.D.	460-2300
<b>NEUROSURGERY</b> Mitchell Levine, M.D.	670-1572
<b>PULMONARY MEDICINE</b> Stephen Karbowitz, M.D.	670-1405
<b>RADIATION ONCOLOGY</b> Dattatreyyudu Nori, M.D.	670-1501
<b>RADIOLOGY</b> William Wolff, M.D.	670-1594
<b>SURGICAL ONCOLOGY</b> Simon Fink, M.D.	670-1120
<b>SURGICAL PATHOLOGY</b> Daisy Saw, M.D. Stanley Kerpel, D.D.S. ( <i>Oral Pathology</i> )	670-1141 670-1520
<b>THORACIC SURGERY</b> Paul Lee, M.D.	670-2707
<b>UROLOGY</b> Albert Tarasuk, M.D.	353-3710
<b>GENETIC COUNSELING</b> Brenda Zak	670-2110
<b>NUTRITION</b> Jack Pasquale, M.D. Mary Grace Sucholet, R.D.	465-0041 670-2550
<b>PAIN MANAGEMENT</b> Peter Silverberg, M.D. Vikas Varma, M.D. Margaret Cawley, R.N.	670-1080 460-1111 670-1422
<b>SOCIAL SERVICE</b> Marlene Smike	670-1300
<b>CANCER RESEARCH</b> Engracio Cortes, M.D. Brij M. Sood, M.D. Chu-Cheng Kan, Ph.D.	279-9101 670-1501 670-1724
<b>ADMINISTRATION</b> Maureen Buglino, R.N., M.P.H. <i>Vice President, Ambulatory Services</i> Tom Deutsch, M.P.H., M.B.A., <i>Administrative Director</i> Vijaya Malladi, C.T.R., <i>Manager</i>	670-1981 670-1501 670-1379

# LAPAROSCOPIC COLECTOMY FOR CANCER

*continued from page 1*

The large US trial, Clinical Outcomes of Surgical Therapy (COST), was published in *The New England Journal of Medicine* in 2004 and had similar results. Intraoperative, 30 day and 60 day morbidity and mortality were the same. Survival, disease free survival, and time to recurrence also showed no difference. Length of hospital stay, analgesic use and incision length were all less after laparoscopic colectomy. This clinical trial with a long (4.4 years) median follow up showed comparable oncologic results for colon cancer. Port site and wound recurrence were both under 1%.

Laparoscopic colectomy has been shown in several studies to have greater benefit in the obese and the elderly patient. Obese patients tend to have more complications and longer surgery times. Hand Assisted Laparoscopic Surgery (HALS), where a hand is used within the abdomen, may shorten the

learning curve for this procedure and lower the risks for obese patients.

There are several concerns when interpreting the results of the COST study. All surgeons who participated in this trial were expert laparoscopic surgeons. They had all passed their learning curve for this procedure. They had to submit videos of their standard laparoscopic right and left colectomies before they were allowed to participate in the trial. If every surgeon who does laparoscopic cholecystectomy and open colectomy started to perform laparoscopic colectomy for cancer, these excellent study results would not be duplicated. Perhaps the early experience with >20% port site recurrence would result. Many institutions, including NYHQ, have struggled with appropriate credentialing policies.

The EAES (European Group) published a consensus statement for laparoscopic resection of colon cancer.

The evidence shows that age is not a contraindication, obesity carries a higher conversion rate, previous surgery is not a contraindication, transmural (T4) tumors should be treated with open resection and high risk patients (ASA 3 and 4) should have limited pneumoperitoneum (<12 mm Hg).

We keep ongoing data for our laparoscopic colectomy patients at NYHQ. Our results have compared favorably to the published literature. Fifty percent of our elective colectomies are now performed laparoscopically. We have an 8.5% conversion rate to open colectomy and a 1% complication rate for anastomotic leak or intraabdominal abscess. Our reoperation rate is 2%. Over the last eight years our 30 day hospital mortality is 1.2%. These results are better than most published series for laparoscopic colectomy.

## HOWARD I. TISZENKEL, M.D.

Howard I. Tiszenkel, M.D. is the Director of Colon and Rectal Surgery at New York Hospital Queens (NYHQ). He is also the Associate Program Director of the NYHQ General Surgery Residency and a Clinical Assistant Professor of Surgery at Weill Medical College of Cornell University.

Before becoming Director of Colon and Rectal Surgery at NYHQ in 1988, Dr. Tiszenkel completed a Fellowship in Colon and Rectal Surgery at the University of Illinois Medical Center. He was a Resident and Chief Resident in Surgery at St. Luke's Roosevelt Hospital in New York, where he also completed his Internship. He received his medical degree from New York Medical College and his BA degree from New York University.

Dr. Tiszenkel is Board Certified in both Colon and Rectal Surgery and



*HOWARD I. TISZENKEL, M.D.*

General Surgery. He has written and had published articles for several professional journals and has done many presentations at national, regional and local conferences.

## SAVE THE DATES, UPCOMING SYMPOSIA

The Cancer Center will be holding the Third Annual NYHQ Lung Cancer Symposium on **Current Directions in Screening and Management of Early Stage Lung Cancer** on November 7, 2006 at the Theresa and Eugene M. Lang Center for Research and Education at NYHQ.

The Cancer Center will also be conducting a symposium on **Nutrition and Cancer** on Dec. 5, 2006 at the Theresa and Eugene M. Lang Center for Research and Education at NYHQ.

Speakers for both events will include NYHQ staff as well as other nationally known experts.

## FEEDBACK FROM OUR PATIENTS

*Patients who send back our patient questionnaire after completing treatment often add comments about how well they were treated. Below is a reprint of recent comments made by one patient. These comments are a reflection of how we try to treat all our patients at NYHQ.*

The staff in general excellent!

Dr. Ravi is great. All the staff at the hospital & Radiation Center were wonderful. Dr. Ravi is personable, caring, compassionate (just a great Doctor).

The reception staff helpful, kind volunteering information to help my treatment. Davida, Paula, Dede and all the wonderful people I'd met, can't remember their names (all great).

My Dr. Karsif from the Breast Center – one of the greatest Doctors I've ever met, did my surgery in 2005 at NYHQ caring, compassionate wonderful women (saved my life).

Nurses Micki, Karen, Shari and Lou all wonderful, thoughtful women who go above and beyond their jobs to make you comfortable.

The technicians Jean, Dan, Cathy, Nicole, Richard, Unis and many others who made me feel comfortable. They were reassuring me and helped me through treatment.

I am so grateful to NYHQ. Both during my surgery and treatments, have helped me recover knowing they were there anytime to help me.

Also, especially Barbara from the Breast Center. She's a gift from the heavens and helped me more than anyone. Patient navigators are helpful for recovery and give you a sense of someone always there.

Thank you

## TUMOR BOARDS / PATIENT CARE CONFERENCES

The **Department of Radiation Oncology** has **New Patient Conferences** every Tuesday morning at 8 am.

**Breast Tumor Board** is held on the second and fourth Wednesday of every month from 12 to 1. Lunch is served. Some upcoming dates are Oct. 11 and Oct. 25.

**Thoracic Tumor Board** is on the third Wednesday of every month from 9 am to 10 am. An upcoming date is Oct. 18.

**Gyn Tumor Board** is held on the first Wednesday of every month from 8 am to 9 am. An upcoming date is Oct. 4.

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

There is one Continuing Medical Education (CME) credit awarded per each Tumor Board meeting attended.

All the above noted professional educational programs are held in the **Anerena M. Anextis Conference Room** in the **Department of Radiation Oncology**. Refreshments are served.

The New York Hospital Medical Center of Queens  
56-45 Main Street, Flushing, NY 11355-5095