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At Summa Akron City and St. Thomas Hospitals, our goal is simple. It is our mission – as is the same across all of Summa Health System – to provide the highest quality, compassionate care to our patients and members and to contribute to a healthier community.

On the following pages, you have the opportunity to see the ways in which exceptional individuals carry forward that mission.

From a clinical perspective to a personal account of an individual’s battle with ovarian cancer, the 2010 oncology annual report provides an overview of the comprehensive, coordinated care delivered in the Jean and Milton Cooper Cancer Center on the campus of Summa Akron City Hospital.

Thank you for your interest in our cancer program. Your support is invaluable as we continually strive to improve treatment and care for those who matter most: our patients and their families.
Analysis of Ovarian Cancer at Summa Akron City and St. Thomas Hospitals

BY STEPHEN J. ANDREWS, M.D.

In 2011, it is estimated that 21,990 women will be diagnosed with ovarian cancer in the United States and that 15,460 will die of the disease. Approximately 600 of these new diagnoses will be in Ohio.

Ovarian cancer is the ninth most common cancer among women and the fifth most common cause of cancer deaths. Among gynecologic cancers, ovarian cancer is the second most common form behind uterine, yet will account for more deaths than all gynecologic cancers combined.

There are three types of ovarian cancer: epithelial, stromal and germ cell. Of these three, epithelial ovarian cancer (EOC) accounts for more than 80 percent of diagnoses and is the focus of this piece.

The epithelium, or covering of the ovary, has the potential to develop into many different cell types, usually mimicking other tissues found in the gynecologic system. In addition, the covering of the ovary shares an embryologic origin with the covering of the inside of the abdomen, called the peritoneum. The most common cell type in EOC is called papillary serous, which mimics the inside lining of the fallopian tube. The histologic distribution of EOC seen at Summa Akron City and St. Thomas Hospitals shows the majority of new diagnoses are of the serous variety (Figure 1, page 6).

Due to the biologic similarities – as well as the similar response to therapy between EOC, primary peritoneal cancer and fallopian tube cancers – these three cancers usually are grouped together. The other main cell types of EOC include endometroid, mucinous and clear cell carcinomas.

The risk of EOC increases with age, with most newly diagnosed women being menopausal. The age distribution seen at time of diagnosis at Summa Akron City and St. Thomas Hospitals is similar to national data (Figure 2, page 6).
A family history of EOC, primary peritoneal cancer, fallopian tube cancer and breast cancer (especially pre-menopausal breast cancer) are the most significant risk factors for developing EOC.

Recent studies have suggested that, among women with such a mutation, the cancer may originate in the fallopian tube and not the ovary itself.

Another genetic condition, known as Lynch Syndrome, places women at high risk for uterine cancer as well. Women with a BRCA mutation are recommended to undergo prophylactic removal of the uterus, fallopian tubes and ovaries when finished with childbearing or by age 35.

EOC is often called the quiet disease, as there are no distinct signs or symptoms to help with diagnosis. Pelvic pain is often the first symptom in early stage EOC. Retrospective reviews have shown that pelvic or abdominal pain, difficulty eating or feeling full quickly and/or urinary issues, such as frequency or urgency, are the most common patient complaints.

The same study indicated that women without EOC often experience similar symptoms. More importantly, women with EOC stated that these symptoms were a true change from their normal state and were frequent. Women should seek medical advice – preferably from a gynecologist – if such symptoms occur daily or for more than a few weeks.

Women with a known mutation in BRCA 1 or BRCA 2 genes are at highest risk, with a 20 to 60 percent chance of developing EOC during their lifetimes. Genetic testing is offered to all newly diagnosed ovarian cancer patients. Approximately 80 percent agree to undergo testing. Roughly eight percent of tested patients yield positive results, which mirrors national statistics.

A family history of EOC, primary peritoneal cancer, fallopian tube cancer and breast cancer (especially pre-menopausal breast cancer) are the most significant risk factors for developing EOC.

The strongest risk factor is a family history of EOC, however, as with breast cancer, only 10 percent of patients diagnosed with EOC have such a history.

Other risk factors include early menarche and late menopause, history of infertility, heavier body weight and a personal history of breast cancer.

Protective factors include pregnancy, breast-feeding and oral contraceptive use. Differences in race are also noted with Caucasian women being more commonly affected than Latina and African-American women (Figure 3, page 6).

Continued on next page.
Currently, there are no approved screening tests for EOC. Women at high risk may choose to undergo screening with annual or biannual CA 125 blood tests and transvaginal ultrasound of the ovaries, although the benefits of such screenings are unproven. Screening with blood tests looking at multiple serum markers also has shown promise but further studies are needed.

Due to the lack of effective screening methods and established early signs and symptoms, EOC is typically diagnosed late. In the United States, 75 to 80 percent of women with EOC are diagnosed at an advanced stage (Stage III or IV) when the cancer has already spread throughout the abdominal cavity or into the chest cavity.

In these women, often the most common sign is a sudden enlargement of abdominal girth due to the accumulation of fluid in the abdominal cavity. Diagnosis is often aided by CT scan of the abdomen and pelvis, which usually shows a complex ovarian mass, omental metastasis and ascites.

Early stage EOC (Stage I and II) is usually not suspected before surgery, with most patients undergoing surgical exploration for a painful pelvic or ovarian mass. Imaging studies such as an ultrasound or CT scan often will show a complex ovarian mass with both solid and cystic components.

Treatment of early stage ovarian cancer requires a thorough and meticulous staging operation. This usually requires removal of the uterus, fallopian tubes and ovaries, along with biopsies of the pelvic and para-aortic lymph nodes, omental removal, abdominal washings and biopsies of multiple sites throughout the abdomen.

Women who still desire fertility can safely be treated with preservation of an unaffected ovary and uterus without decreasing chance of overall survival. Studies have shown that women with early EOC who undergo complete staging have a better outcome. Most women with early stage EOC will require chemotherapy with a platinum and a taxane for three to six courses.

A recent Gynecologic Oncology Group (GOG) study showed no advantage to an additional 24 weeks of maintenance taxane chemotherapy in early stage patients. In addition, there appears to be a lower recurrence rate with six versus three courses of adjuvant therapy.

Treatment of advanced stage EOC requires a combination of surgery and chemotherapy. The complete surgical excision (debulking) of all visible cancer has consistently been shown to enhance overall survival and should be the goal of the operating surgeon, preferably a gynecologic oncologist.

After debulking surgery, patients are treated with a combination of a platinum and a taxane for a minimum of six courses. Several randomized studies have shown a distinct survival advantage to utilizing both intravenous and intraperitoneal chemotherapy. The use of neoadjuvant chemotherapy is often utilized for those women thought to have surgically unresectable disease or who are poor surgical candidates for a major debulking operation due to other medical co-morbidities and/or poor nutritional status.
A recent European study has shown this approach, combined with interval debulking, not to be inferior in terms of overall survival. However, the complete removal of all visible tumor was the most important factor in improving survival, regardless of the timing of the surgery.

A recent report presented at the Society of Gynecologic Oncology, utilizing SEER data, reviewed the care of more than 4,300 Medicare participants over a 10-year period with a diagnosis of EOC. Surprisingly, only 40 percent of these Medicare patients from across the nation received the recommended treatment of both six courses of chemotherapy and surgery.

EOC survival, as with most cancers, is closely related to stage at diagnosis. Early stage EOC has an excellent survival rate of 94 percent, however, as mentioned earlier, only a minority (15 to 20 percent) of patients are diagnosed at this early stage. Although the five-year survival rate of advanced-stage EOC (III and IV) has increased over the last several years, it is still only 28 to 30 percent.

As illustrated in Figures 4 through 6 (page 7), patients diagnosed and treated at Summa Akron City and St. Thomas Hospitals compare favorably to those diagnosed and treated throughout Ohio and the United States in terms of two- and five-year survival.

A major improvement in the treatment of advanced EOC was reported in 2010, showing an advantage in progression-free survival with the addition of the anti-angiogenic agent bevacizumab in combination with a platinum based regiment for six courses followed by a maintenance course of bevacizumab. The impact on long-term survival is not yet known.

Further study in the use of bevacizumab in the primary treatment of EOC as well as maintenance therapy is available through GOG protocols at Summa Akron City and St. Thomas Hospitals. The use of this novel agent is also being studied in recurrent EOC by the GOG, which is also available at Summa Akron City and St. Thomas Hospitals.

For women with BRCA mutations, the use of a drug that inhibits an enzyme used in cellular DNA repair and PARP inhibitors has also shown promise in the treatment of EOC.

For more information regarding treatment of ovarian cancer at Summa Akron City and St. Thomas Hospitals, please visit summahealth.org/cancer or call (330) 375-6101.
Figure 1: 2010 Ovarian Cases – Histologies
Summa Akron City and St. Thomas Hospitals

<table>
<thead>
<tr>
<th>Histology</th>
<th>Number of Cases</th>
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<tbody>
<tr>
<td>SEROUS CYSTADENOCARCINOMA</td>
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<tr>
<td>PAPILLARY SEROUS CYSTADENOCARCINOMA</td>
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</tr>
<tr>
<td>PAPILLARY CYSTADENOMA BORDERLINE MALIGNANCY</td>
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</tr>
<tr>
<td>MUCINOUS ADENOCARCINOMA</td>
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</tr>
<tr>
<td>ENDOMETROID CARCINOMA</td>
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</tr>
<tr>
<td>ADENOCARCINOMA</td>
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</table>

Figure 2: 2010 Ovarian Cases – Age at Diagnosis
Summa Akron City and St. Thomas Hospitals

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<tr>
<td>50 - 59</td>
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<tr>
<td>40 - 49</td>
<td>4</td>
</tr>
<tr>
<td>30 - 39</td>
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</tbody>
</table>

Figure 3: 2010 Ovarian Cases – Distribution by Race
Summa Akron City and St. Thomas Hospitals

<table>
<thead>
<tr>
<th>Race</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFRICAN AMERICAN</td>
<td>10%</td>
</tr>
<tr>
<td>CAUCASIAN</td>
<td>90%</td>
</tr>
</tbody>
</table>
Figure 4: Observed Survival for Ovarian Cases
Summa Akron City and St. Thomas Hospitals – Data from 1 Program • Cases Diagnosed 1998 - 2002

Figure 5: Observed Survival for Ovarian Cases
Ohio – Data from 78 Programs • Cases Diagnosed 1998 - 2002

Figure 6: Observed Survival for Ovarian Cases
National – Data from 1,332 Programs • Cases Diagnosed 1998 - 2002
Mary Ann Gehring, 57, has lived with her husband in Green, Ohio, since their oldest son was born. A registered nurse, she worked part-time in a pain-management practice to allow for some much needed flexibility in the family schedule. Though hectic at times (like most families), life for the Gehrings seemed to be in good order.

In April 2010, Mary Ann was in for a regularly scheduled visit with her gynecologist and had a Pap test as part of her routine check-up. After examining the results, Mary Ann’s physician found abnormalities among the gathered cells.

“My doctor found endometrial cells, which was unusual for a woman my age,” Mary Ann said.

Her gynecologist recommended a uterine biopsy to determine if the endometrial cells were benign or malignant.

“I’ve been healthy my entire life,” Mary Ann said. “I had some problems with my hip and neck – a result of sitting at my work station. But, other than that, I’ve always been healthy…”

After a brief pause, she continued: “That’s why my diagnosis came as such a shock.”
“I’ve been healthy my entire life. I had some problems with my hip and neck – a result of sitting at my work station. But, other than that, I’ve always been healthy. That’s why my diagnosis came as such a shock.” – Mary Ann Gehring

Mary Ann’s case was especially surprising because she was young compared to most women diagnosed with this form of the disease. Furthermore, she was a non-smoker, was not overweight and had two children, all of which decrease the chances of ovarian cancer.

**Signs and Symptoms**

According to the National Cancer Institute, the most common signs of ovarian cancer are:

- Pressure or pain in the abdomen, pelvis, back or legs
- Swollen or bloated abdomen
- Nausea, indigestion, gas, constipation or diarrhea
- Regular or constant fatigue

Less common symptoms include shortness of breath, frequent urination and abnormal vaginal bleeding.

Mary Ann was completely unaware of her condition until her visit to the gynecologist.

“Looking back, I did feel pretty worn down, but I figured it was just from everyday life,” Mary Ann said. “Nothing out of the ordinary, at least I thought.”

In addition to fatigue, Mary Ann said she likely experienced some mild bladder changes (frequency) but nothing severe. “I thought I was just getting older,” she said with a laugh.

**Referral and Treatment Plan**

Mary Ann’s gynecologist referred her to a gynecologic oncologist at Summa Akron City and St. Thomas Hospitals, Stephen J. Andrews, M.D.

A well known and respected physician and surgeon, Dr. Andrews practices alongside Vivian von Gruenigen, M.D. – a nationally renowned gynecologic oncologist. Their practice is located in the Jean and Milton Cooper Cancer Center on the campus of Summa Akron City Hospital.

Mary Ann and Dr. Andrews met for an initial consultation. Based on her uterine biopsy, Dr. Andrews recommended a complete hysterectomy followed by chemotherapy.

“We really make sure our patients never get ‘lost in the crowd,’” Dr. Andrews said. “Our size and facility – the Jean and Milton Cooper Cancer Center – really work to our advantage.”

When asked what he considers the most rewarding part of his work, Dr. Andrews provided a clear and simple answer: “Helping patients through their most difficult times.”

**Stephen J. Andrews, M.D.  Gynecologic Oncologist/Surgeon**

Dr. Andrews serves as the primary guide, source of information and caregiver for his patients throughout the entire treatment process.

As Mary Ann’s physician, Dr. Andrews successfully performed surgery, prescribed and oversaw chemotherapy and, most importantly, developed a sense of trust that Mary Ann described as the most significant factor in choosing her healthcare provider.
“Even though I went for a second opinion and I researched other options for care, Dr. Andrews and the facility (Jean and Milton Cooper Cancer Center) really made me want to stay.”
– Mary Ann Gehring

As many cancer patients do, Mary Ann went for a second opinion to confirm Dr. Andrews’ recommended treatment plan. Her second opinion resulted in the same findings and prescribed treatment.

“Even though I went for a second opinion and I researched other options for care, Dr. Andrews and the facility (Jean and Milton Cooper Cancer Center) really made me want to stay,” Mary Ann said. “He’s personable, informative, professional – and it’s a beautiful place.”

Once she decided to seek treatment at Summa Health System, Dr. Andrews scheduled Mary Ann’s hysterectomy for May 25, 2010.

Surgery

“I still couldn’t believe it – I had cancer,” Mary Ann said. “But everything happened so fast, I think I was still in shock leading up to surgery.”

Dr. Andrews initially planned to perform Mary Ann’s hysterectomy using a robotic procedure due to its numerous benefits to the patient, including:

- Reduced blood loss during surgery
- Smaller incisions/less scarring
- Fewer complications (e.g., chance of infection)
- Shorter hospital stay
- Faster recovery

In the early stages of surgical preparation, Dr. Andrews examined Mary Ann’s reproductive system using a laparoscope.

“We quickly realized we were dealing with a more involved disease process than we originally anticipated,” Dr. Andrews said. “We had to go with a fully open procedure for complete debulking (removal) of Mary Ann’s cancer.”

Even though Dr. Andrews had to perform an open hysterectomy, Mary Ann’s surgery was very successful – no complications.

The pathology report indicated Mary Ann’s cancer had reached Stage IIIC, a more advanced stage of the disease with metastases greater than 2 centimeters in size. Fortunately, all removed lymph nodes tested negative.

Mary Ann then needed a few weeks to recover from surgery and to prepare for the longer, more difficult portion of her treatment.
Chemotherapy

Before her hysterectomy, Dr. Andrews informed Mary Ann of her eligibility to participate in a clinical trial – Gynecologic Oncology Group (GOG) protocol 0252. She quickly agreed to enroll.

“I was excited to participate in the clinical trial,” Mary Ann said. “I was essentially going to receive the standard of care with additional chemotherapy that could potentially supplement first-line treatment.”

Lynn Kaplan, RN, BSN, OCN, a clinical research nurse, was responsible for monitoring Mary Ann’s progress and ensuring her treatment met all necessary protocol requirements.

“I started working with Mary Ann shortly after she began treatment,” Lynn said. “Mary Ann really dealt with a difficult regimen. It can be hard to tolerate.”

Protocol required Mary Ann to have two ports installed for chemotherapy. The first was installed between her shoulder and upper breast for intravenous therapy (IV) and the second in the abdominal cavity for intraperitoneal (IP) therapy.

“The purpose of this trial is to help determine if patients need IP in addition to IV therapy,” Lynn said. “This trial is focused on an advanced stage of the disease, so it requires advanced treatment – two forms of cell kill. But you never want to risk over-treating a patient.”

Though her chemotherapy was intense, Mary Ann responded very well.

“Oddly enough, I felt great the day after chemo, which really surprised me. Then, a few days later, I really started to feel it,” Mary Ann said.

She experienced some of the more common side effects – nausea, fatigue, neuropathy in her feet and a metallic taste in her mouth. Dr. Andrews provided her with supplemental medication to help with nausea, which Mary Ann said made a significant improvement.

Her induction began in July 2010 and was followed by one year of maintenance therapy, which began in September 2010.

Chemotherapy Overview

Gynecologic Oncology Group
Protocol: 0252
Treatment Overview:
- Paclitaxel (IV)
- Carboplatin (IP)
- Bevacizumab (IV)

Lynn Kaplan, RN, BSN, OCN
Clinical Research Nurse

As a clinical research nurse, Lynn Kaplan is responsible for identifying, screening and enrolling eligible cancer patients in clinical trials. She also monitors their treatment to ensure they remain within protocol.

Kaplan wasn’t the research nurse who enrolled Mary Ann in her clinical trial, but did start monitoring her treatment shortly after she began chemotherapy.

“We would have a clinical trial for every patient who walked through the door if we could,” Kaplan said. “Clinical trials are the best, most effective way of advancing cancer care.”

The dedication to clinical research is what Kaplan thinks sets Summa’s cancer program apart from other providers.

“All our physicians and staff support the research side of our program,” Kaplan said. “It improves treatment capability but also ensures patients have access to the most advanced treatment available.”
ATTEMPTING TO NAVIGATE CANCER TREATMENT IS NO SIMPLE TASK, ESPECIALLY WHEN IT INCLUDES SURGERY, CHEMOTHERAPY AND FOLLOW-UP APPOINTMENTS. FORTUNATELY FOR MARY ANN, SHE NEVER HAD TO GO FAR FOR SUPPORT.

Eileen Simcox, RN, is a clinical care coordinator in Dr. Andrews’ practice. She provides general care and support for gynecologic oncology patients — support with chemotherapy and its side effects, pre- and post-operative issues, managing medications and more.

Though Simcox joined Summa Health System after Mary Ann began treatment, she has had a great deal of interaction with her.

“Mary Ann is great,” Eileen said. “She always has a positive attitude, she’s compliant with recommended treatment, she’s just a great patient.”

Simcox was responsible for arranging Mary Ann’s follow-up appointments and tests. She worked very closely with clinical research and outpatient infusion to ensure her treatment always remained within protocol.

“Eileen and the medical staff were wonderful. I had questions every day,” Mary Ann said. “They always had answers for me. Any time I had a test or exam, Dr. Andrews would call me personally to ensure I understood everything.”

“At Summa, we really work together — across the board — to make sure we’re doing the best we can for every patient,” Eileen said. “This really is a team-based environment. The nurses, physicians and support staff interact constantly and on a daily basis — all to benefit our patients.”

Experience

Now that she has recovered from surgery and completed a majority of her chemotherapy, Mary Ann is in the last stages of her maintenance treatment at the Jean and Milton Cooper Cancer Center.

Though she was in a situation she never expected, when asked about her experience, Mary Ann responded: “Coming here has been top-notch. Everyone from the support staff to physicians has been great. It’s really a stress-free environment.”

She does provide direct patient care but is involved in a great deal of collaboration with other staff members throughout oncology, primarily to support patients as they navigate treatment.

“It’s really rewarding. You’re able to help patients during their most difficult times,” Eileen said. “And I get to work directly with exceptional physicians and staff.”

In addition to the layout and services available within the cancer center, Simcox said the people who staff the Jean and Milton Cooper Cancer Center make the real difference.

“Summa is very team oriented. We strive to provide the very best patient care. And that’s the expectation from everyone — physicians, nurses, everyone.”
But that’s not the most surprising aspect of Mary Ann’s experience at Summa Health System.

“I’m probably the only person who would tell you this, but I loved chemo! We had a great time,” Mary Ann said while laughing. “I still joke with Sharon and tell her I want to work here!”

Sharon Walsh, RN, staff nurse, outpatient infusion, who knew Mary Ann from their days in nursing school, was one of Mary Ann’s staff nurses in the infusion center and would regularly administer her chemotherapy treatments.

“She’s been through a lot, but she still has a really positive attitude,” Sharon said. “She was really motivated to fight through the cancer and her side effects. She’s an inspiring patient and person.”

In addition to the care and support she received in the cancer center, Mary Ann’s mindset had a lot to do with her experience.


Just as important, Mary Ann said she made a point to never feel sorry for herself or feel victimized.

“You have to stay positive. Lean on your support system,” Mary Ann said. “Let the people in your life help you, especially when they’re eager to do it. It helps you and them.”

She added that staying positive is substantially easier when you have confidence in your care team – physicians, nurses and support staff.

“The people around you can help you enjoy the journey as much as possible,” Mary Ann said. “It’s hard, you’ll be in pain and it’s nothing you ever want to do…”

“But you get through it,” she concluded, “and enjoy everything you can.”
Site: Cervix

- **Protocol:** GOG 0240
  A Randomized Phase III Trial of Cisplatin Plus Paclitaxel with and without NCI-Supplied Bevacizumab versus the Non-Platinum Doublet, Topotecan Plus Paclitaxel, with and without NCI-Supplied Bevacizumab, in Stage IVB Recurrent or Persistent Carcinoma of the Cervix

**Eligibility Criteria:** Primary Stage IVB, recurrent or persistent cancer of the cervix; not treatable by surgery or radiation therapy; measurable disease, GOG performance status 0-1; more than 6 weeks since surgery or chemo/radiation therapy or more than 3 weeks since radiation therapy only; no CNS metastases; no prior anti-VEGF drugs including bevacizumab; no prior chemotherapy unless given with radiation therapy

- **Protocol:** GOG 0263
  Randomized Phase III Clinical Trial of Adjuvant Radiation versus Chemoradiation in Intermediate Risk Stage I/IIA Cervical Cancer Treated with Initial Radical Hysterectomy and Pelvic Lymphadenectomy

**Eligibility Criteria:** Squamous cell, adenosquamous, adenocarcinoma Stage I-IIA; radical hysterectomy and pelvic lymphadenectomy; no tumor in the parametria, pelvic lymph nodes or other extra-uterine site; GOG performance status 0-2; surgery between 3 and 8 weeks of study entry, no prior radiation therapy or chemotherapy, no concurrent brachytherapy boost

Site: Endometrium

- **Protocol:** GOG 0086P
  Paclitaxel, Carboplatin and Bevacizumab or Paclitaxel, Carboplatin and Temsirolimus or Ixabepilone, Carboplatin and Bevacizumab in Treating Patients with Stage III, Stage IV or Recurrent Endometrial Cancer

**Eligibility Criteria:** Endometrial cancer; Stage III, IVA-B or recurrent disease; measurable disease, no CNS disease; not eligible for a higher priority GOG protocol > 4 weeks since prior radiation therapy; prior hormonal therapy more than 1 week before study entry; > 28 days since surgery or open biopsy; > 7 days since closed biopsy; no prior chemotherapy; GOG performance status 0-2

- **Protocol:** GOG 0210
  Molecular Staging of Endometrial Cancer

**Eligibility Criteria:** Patients with endometrial cancer who will undergo full surgical staging; all stages, grades and histologic subtypes will be eligible; must be suitable candidates for surgery; no prior retroperitoneal surgery or prior pelvic or abdominal radiation therapy; not pregnant
Protocol: GOG 0249
A Phase III Trial of Pelvic Radiation Therapy versus Vaginal Cuff Brachytherapy Followed by Paclitaxel/Carboplatin Chemotherapy in Patients with High Risk, Early Stage Endometrial Carcinoma

Eligibility Criteria: Stage I high-intermediate risk (grade 2 or 3, lymphovascular space invasion, and/or myometrial invasion); Stage II with or without risk factors; Stage I-II disease with serous or clear cell histology with or without other risk factors provided disease is confined to the uterus; no metastases; total hysterectomy four to 12 weeks before study entry; GOG performance status 0-2

Protocol: GOG 0258
A Randomized Phase III Trial of Cisplatin and Tumor Volume Directed Irradiation Followed by Carboplatin and Paclitaxel versus Carboplatin and Paclitaxel for Optimally Debulked, Advanced Endometrial Carcinoma

Eligibility Criteria: Stage III or IVA endometrial cancer; GOG performance status 0-2; no recurrent endometrial cancer; no carcinosarcoma; no prior pelvic or abdominal radiation therapy; no prior chemotherapy for endometrial cancer

Protocol: GOG 0131H
A Phase II Evaluation of Ixabepilone in the Treatment of Recurrent or Persistent Leiomyosarcoma of the Uterus

Eligibility Criteria: Persistent or recurrent disease refractory to treatment; measurable disease; must have > 1 target lesion; not eligible for a higher priority GOG protocol; must have had one prior regimen that included a taxane; no brain metastases; GOG performance status 0-2; more than one week since hormonal therapy; more than 3 weeks since chemotherapy; more than 4 weeks since radiation therapy

Protocol: GOG 0170P
A Phase II Evaluation of AMG 102 in the Treatment of Persistent or Recurrent Epithelial Ovarian, Fallopian Tube or Primary Peritoneal Carcinoma

Eligibility Criteria: Recurrent or persistent ovarian epithelial, fallopian tube or primary peritoneal cancer, measurable disease; > 1 target lesion; 1 prior platinum-based chemotherapy, more than 30 days since surgery; more than 3 weeks since prior treatment including immunologic agents; more than one week since prior hormonal therapy; GOG performance status 0-2

Protocol: GOG 0213
Carboplatin and Paclitaxel With or Without Bevacizumab After Surgery in Treating Patients With Recurrent Ovarian Epithelial Cancer; Primary Peritoneal Cavity Cancer or Fallopian Tube Cancer

Eligibility Criteria: Recurrent disease; had been disease free for 6 months; at least one lesion must be > 20 mm by MRI or CT scan or > 10 mm measured by spiral CT scan; GOG performance status 0-2; only 1 prior chemotherapy treatment; no prior radiation treatment; no CNS disease; no concurrent immunotherapy or radiotherapy planned
Protocol: GOG 0241
A Phase III Trial of Open Label Carboplatin and Paclitaxel with or without Bevacizumab Compared with Oxaliplatin and Capecitabine with or without Bevacizumab as First Line Chemotherapy in Patients with Mucinous Epithelial Ovarian Cancer or Fallopian Tube Cancer

Eligibility Criteria: Mucinous carcinoma of the ovary or fallopian tube; FIGO stage II-IV or recurrent stage I, no primary peritoneal cancer; no brain metastases; GOG performance status 0-2; life expectancy greater than 3 months; no prior chemotherapy, radiation therapy or mouse CA125 antibody; more than 4 weeks since surgery; no surgery planned during study treatment

Protocol: GOG 0252
Bevacizumab and Intravenous or Intraperitoneal Chemotherapy in Treating Patients with Stage II or Stage III Ovarian Epithelial Cancer, Fallopian Tube Cancer or Primary Peritoneal Cancer

Eligibility Criteria: Stage II or Stage III with ≤ 1 cm residual disease; no radiographically measurable disease; 12 weeks or less since surgery; no brain tumor or metastases; no prior treatment; GOG performance status 0-2

Protocol: GOG 0259
Nurse-Delivered Write Symptoms® vs. Self-Directed Write Symptoms® vs Care as Usual for Optimal Symptom Management for Women with Recurrent Ovarian, Fallopian Tube or Primary Peritoneal Cancer

Eligibility Criteria: Ovarian, fallopian tube or primary peritoneal cancer that has recurred or persisted following primary therapy; must be experiencing > 3 symptoms associated with cancer or cancer therapy; GOG performance status 0-2; able to read and write English; access to computer and internet

Protocol: GOG 0262
Paclitaxel and Carboplatin with or without Bevacizumab in Treating Patients with Stage III or IV Ovarian Epithelial Cancer, Primary Peritoneal Cancer or Fallopian Tube Cancer

Eligibility Criteria: FIGO stage III with > 1 cm residual disease or Stage IV; no borderline epithelial ovarian cancer; no CNS or brain metastases; GOG performance status 0-2, < 12 weeks since surgery; no prior radiation therapy, chemotherapy or targeted therapy

Site: Uterus

Protocol: GOG 0130F
A Phase II Evaluation of Ixabepilone in the Treatment of Recurrent or Persistent Carcinosarcoma of the Uterus

Eligibility Criteria: Uterine carcinosarcoma; progressive disease; measurable disease; must have > 1 target lesion; must have had 1 prior chemotherapy; more than 3 weeks since prior therapy; more than 1 week since prior hormonal therapy; 1 prior non-cytotoxic therapy allowed; GOG performance status 0-2

Protocol: GOG 0238
A Randomized Trial of Pelvic Irradiation with or without Concurrent Weekly Cisplatin in Patients with Pelvic-Only Recurrence of Carcinoma of the Uterine Corpus

Eligibility Criteria: Recurrent endometrial cancer confined to the pelvis and/or vagina; no evidence of extra pelvic disease; GOG performance status 0-2; prior primary surgical debulking okay if residual disease is evaluable; more than 6 months since prior hormone or chemotherapy; no prior radiation therapy; no neoadjuvant chemotherapy for recurrent disease

For more information regarding cancer clinical trials at Summa Akron City and St. Thomas Hospitals or for a complete list of open protocols and corresponding sites, please contact Joyce Neading, program director, cancer research and cancer registry, (330) 375-4221 or neadinja@summahealth.org.
Accomplishments

Programmatic

- Continued implementation of the system-wide three-year oncology strategic plan, with emphasis and focus on key strategies and tactics specific to year two.
- Prepared for and successfully completed American College of Surgeons Commission on Cancer® three-year reaccreditation survey.

Clinical

- Expanded service area to include Medina County, Ohio, with the opening of Summa Health Center at Lake Medina. Available cancer services include: medical oncology, gynecologic oncology, radiation oncology and outpatient infusion. Summa Health System is the sole provider of radiation therapy in the City of Medina and Brainlab’s ExacTrac® technology in Medina County.

Quality

- Evaluated process and planning for implementation of CPOE and an electronic medical record system for outpatient oncology services (infusion and office-based practices).
- Began planning and the development of a formalized genetics program and component to oncology services.

Community Outreach

- Conducted a needs assessment for patients and providers specifically focused on cancer survivorship.
- Recruited members of cancer committee to form a multidisciplinary survivorship sub-committee. First meeting was held during the first quarter of 2010.
- Hosted a skin cancer awareness day to raise awareness and emphasize the importance of prevention among members of the greater community.
- In collaboration with the American Cancer Society’s BEST program, implemented a free mammography program for uninsured and underinsured women to receive necessary/recommended breast cancer screenings.
### 2010 Primary Sites
Summa Akron City and St. Thomas Hospitals

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# 2010 Most Common Primary Sites

Summa Akron City and St. Thomas Hospitals

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# 2010 Annual Report Data

Summa Akron City and St. Thomas Hospitals

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Medical Director’s Summary
BY R. DOUGLAS TROCHELMAN, M.D.

The year 2010 resulted in the continued growth and development of the cancer program at Summa Akron City and St. Thomas Hospitals as the Akron region’s most frequent destination for cancer care and treatment.

There were 1,229 new analytic cases diagnosed at the Jean and Milton Cooper Cancer Center in 2010, representing a broad spectrum of invasive malignancies. This wide variety of diagnoses closely paralleled the national experience, as reported by other institutions. Two-thirds of our newly diagnosed patients were over the age of 60, reflecting the reality of cancer as a disease of aging populations.

Approximately three-fourths of our patients resided in Summit County, with the majority of remaining patients coming from Portage, Stark, Medina and Wayne counties. While most of our newly diagnosed patients were insured, the staff at Summa Akron City and St. Thomas Hospitals continued to manifest Summa Health System’s mission by providing care to community members regardless of ability to pay for treatment.

Breast cancer continued to represent our most commonly diagnosed site of invasive cancer with 240 new diagnoses in 2010. Lung cancer continued to be a common site as well with 200 new analytic cases diagnosed in 2010 — a small decrease in incidence since 2009. We will continue to monitor that trend locally and nationally in the years ahead, as future plans for prevention and screening take shape.

Other frequent sites of newly diagnosed invasive malignancy include colon and rectum (155), uterus (74), non-Hodgkin’s Lymphoma (66), prostate (55) and bladder (52).

A total of 127 patients availed themselves of the opportunity to participate in investigational clinical trials. This participation level of 10 percent earned the cancer program at Summa Akron City and St. Thomas Hospitals recognition at the “commendation” level by the American College of Surgeons Commission on Cancer.

Programmatically, 2010 was a busy year with the ongoing implementation of the system-wide three-year oncology strategic plan. The cancer program continued its participation in the system-wide integration process to ensure uniform care across all Summa Health System locations.

In addition, we prepared for and successfully completed the American College of Surgeons Commission on Cancer three-year accreditation survey, resulting in “commendation” in all eight categories evaluated by reviewers. This outstanding level of recognition reflects the dedication of all personnel who work together to provide our form of care in a compassionate and patient-centered environment.

Quality improvement measures included planning for an electronic medical records system with computerized physician order entry for the Jean and Milton Cooper Cancer Center. Initial planning began for the addition of a formalized genetics program as well. Both undertakings are expected to yield considerable benefits for our patients in the years ahead.

Community outreach continued to be a major focus of the cancer program. The Jean and Milton Cooper Cancer Center hosted a skin cancer awareness day to help emphasize the importance of prevention in the battle against melanoma and other malignancies of the skin. The American Cancer Society’s BEST program was a source of funding for uninsured and underinsured women in need of breast cancer screening. Our partnership with the American Cancer Society continued to benefit members of our community at large.

In addition, members of the cancer committee were recruited to form a survivorship sub-committee. This group will help address the needs and concerns of the ever increasing number of successfully treated patients.

Stephen J. Andrews, M.D., has provided an interesting and detailed overview of ovarian cancer at Summa Akron City and St. Thomas Hospitals. His review, as well as the perspective provided by one of our patients, should offer valuable insight regarding this disease and perhaps make clear the source of passion and dedication that drives our exceptional team of healthcare professionals at Summa Health System.

R. Douglas Trochelman, M.D.
Medical Director
Oncology Service Line
Summa Health System
Leadership

Thomas J. Strauss
President and
Chief Executive Officer
Summa Health System

Unhee Kim, RN, MBA
System Vice President,
Service Lines and
Ancillary Services
Summa Health System

R. Douglas Trochelman, M.D.
Medical Director,
Oncology Service Line
Summa Health System

Brian Rentschler, MBA
System Director,
Oncology Service Line
Summa Health System

Joyce Neading, RHIT, CTR
Program Director, Cancer
Research and Cancer Registry
Summa Health System

2010 Annual Report
Project Committee

Kimberly Holm, MBA
Marketing Manager

Jason Lee
Manager, Interactive Services

Kristen Manes, MBA
Manager, Print and Process Improvement

Jim McConihe
Manager, Graphic Design

Joyce Neading, RHIT, CTR
Program Director, Cancer Research and Cancer Registry

Brian Rentschler, MBA
System Director, Oncology Service Line

Nathan Sargent
Communications Associate

Peggy Schlosser, LPN, CTR
Cancer Registrar

Rose Skinner
Cancer Registrar

Stephen J. Andrews, M.D.
Gynecologic Oncologist

Jeannie Terry, CTR
Cancer Registrar

R. Douglas Trochelman, M.D.
Medical Director, Oncology Service Line

Gary Yasaki
Photographer, Yasaki Photographic

Summa Health System
Cancer Committee

Drew Abramovich, M.D.
Stephen Andrews, M.D.
Catherine Bentley
Scott Berry
Rebecca Brown
Dawn Canda
Monica Caruso, RN, OCN
Raymond Clarke, M.D.
Deborah Damore
Joseph Dankoff, M.D.
William Demas, M.D.
Desiree Doncals, M.D.
Jeanette Doria
Risa Dunn, M.D.
Heidi Eve-Cahoon, CNP
Daniel Finelli, M.D.
Steven Folk, Pharm.D.
Elisabeth Hanna, RN, CCRN
Kimberly Holm
Susan Hong, M.D.
Lynn Kaplan, RN, OCN
Lauren Kinsele, M.D.
Melinda Koch
Joseph Koenig, M.D.
Kim Kousale
John Lahorra, M.D.
Paula Lett, RN
Erik Lichtenberger, M.D.,
Cancer Liaison Physician
Joseph Myers, M.D.
Joyce Neading, RHIT, CTR
Sally Olszewski, RN, OCN
Susan Popovici, LISW-S
Steven Radwany, M.D.
Pars Ravichandran, M.D.
Sarah Reimer, Ph.D.
Brian Rentschler
Erin Roberts, American Cancer Society
Nathan Sargent
Barb Saylor, RN, OCN
Margaret Schlosser, LPN, CTR
Marlo Schmidt, ACT
Rose Skinner
Frederick A. Slezak, M.D.
Shelley Green
Jeannie Terry, CTR
R. Douglas Trochelman, M.D., Chair
Scott Weiner, M.D.
Gary Williams, M.D

Summa Akron City and St. Thomas Hospitals
Oncology Service Line

2010 Annual Report
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Gary Yasaki
Photographer, Yasaki Photographic

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Summa Akron City and St. Thomas Hospitals
Cancer Annual Report

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Volume: XVII

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National Cancer Database
Summa Akron City and St. Thomas Hospitals Tumor Registry

Written Contributions:
Andrews, Stephen J., M.D.
Analysis of Ovarian Cancer at Summa Akron City and St.
Thomas Hospitals (2011).

Sargent, Nathan D.
The Experience: A Woman’s Fight Against Ovarian Cancer (2011).

Trochelman, R. Douglas, M.D.
Medical Director’s Summary (2011).

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summahealth.org/cancer

summahealth.org