

Community Cancer Center

2006 ANNUAL REPORT



Rutland Regional Medical Center

Community Cancer Center

Cancer Program Committee Members

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Pathology

J.C. Biebuyck, MD
Diagnostic Imaging

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Breast Care Program

Bruce Bullock, MD
Family Medicine

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Clare Coppock, RPH
CCC – Pharmacist

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Susie Lebel, RN
Community Education

Michael Garcia, MD
Family practice

Erica Tamblini, MSW
CCC – Social Work



Chairman's Report

2006 marks a small change in the format of the annual report. In the past, the format of the annual report followed a template designed by the American College of Surgeons. Although we continue to participate in the American College of Surgeons program for accreditation, the annual report requirement has been dropped. We still feel there is much to convey to the greater Rutland community and we have decided to continue our report publication. We have expanded the report's content to include, not only past requirements dictated by the college but also new articles and features which reflect the breadth of services, programs, and projects which fall under the purview of the cancer center and cancer program.

Dr. Richard Lovett continues to lead the Radiation Oncology program at Rutland Regional Medical Center. Dr. Lovett and the hospital have made a commitment to maintain cutting edge technology in a community setting. Services such as IMRT, IGRT (*using sonogram guidance*), and state-of-the-art physics planning and computerized software allow patients in our community to receive radiation care close to home. Pending final proposal approval, radiation seed therapy for early stage prostate cancer will become a reality in 2007. We applaud Dr. Lovett and the entire radiation oncology team for their expertise and dedication to patient care.

The Palliative Care Program has grown exponentially in 2006. Palliative care has been recognized as an essential part of both the inpatient and outpatient services not just for cancer patients, but for any patient with any advanced disease. Elizabeth McGrath, NP and Erica Tamblini, CSW have maintained and expanded the palliative care program in the community cancer center where it has been fully operational for several years. The inpatient palliative care program, directed by Eva Zivitz, RN has been embraced hospital-wide. The program has expanded to include any hospitalized patient. Special areas of interest include the emergency department, intensive care unit and cardiac monitoring areas.

Breast MRI has been offered at Rutland Regional since 2001. For three years (2003 – 2006), over 500 patients participated in a study of breast MRI in high-risk women. This study was performed in cooperation with Blue Cross and Blue Shield of Vermont. During 2006, BCBS VT published new guidelines in which the recommendations for breast MRI were delineated. We have been proud of our collaboration with BCBS VT and look forward to more successful cooperative endeavors.

2006 saw a major effort to add complementary health care services to conventional therapies offered in the cancer center. Glen Harder, a licensed acupuncturist and practitioner of Chinese medicine began a very successful collaboration with the cancer center. Glen has helped numerous cancer center patients improve their quality of life by helping to relieve pain, control nausea, and, among other things, help patients take personal responsibility for nutritional and physical health choices. We deeply appreciated Glen's willingness to see and treat so many cancer center patients.

Many other projects have been identified and are in early phases of development. Some include a focus on bereavement for our patients/families not enrolled in the hospice program, Schwartz rounds (*a forum for discussion of emotionally demanding issues for the medical staff*), community education projects, and formal comparison of outcomes data at Rutland Regional to national benchmarks. These and other projects help provide the best care possible to our community.

As always, our hats go off to our wonderful oncology nurses. All of our nurses are oncology certified and continue to update their certifications when required by the Oncology Nursing Society. They continue as a beacon of light for our patients and families. Our nurses are always there with a friendly "hello", treating patients like their own family, and never tiring in their efforts to provide the very best care. What a gift we have!

A handwritten signature in black ink, appearing to read "Allan Eisemann MD". The signature is written in a cursive, flowing style.

Allan Eisemann, MD
Chairman, Cancer Committee

COMMUNITY CANCER CENTER ACTIVITIES FOR 2006

- FEBRUARY** **Cancer Program Meeting**
WCAX Commercial Dr. Richard Lovett To Speak On IMRT
Oncology Nurses' Day – Dr. Byock
- MARCH** **Daffodil Days for All Patients**
- APRIL** **Cancer Program Meeting**
Glen Harder Here for All Staff Staff Meeting
Ccc Staff Volunteer for Courier Helpers
- MAY** **Nomos Here for Ultrasound Training**
Dr. Lovett To Speak at the Weekend of Hope in Stowe
Palliative Care Class for All RN's
Dr. Eisemann To Speak at the Prostare Support Group
- JUNE** **Survivor's Day Event at South Station Restaurant**
Tug of War Event
Relay for Life Weekend
Alan Woodard Memorial Ride
- JULY** **Komen Race for the Cure**
- AUGUST** **Staff Meeting**
Dick Currier Memorial Baseball Weekend
- SEPTEMBER** **Rutland Herald Interview with Dr. Richard Lovett and Dr. Ernest Bove**
- OCTOBER** **Alan Woodard Check Presentation**
Benefit Bingo in Memory of Eleanor Laplante
Dick Currier Check Presentation
- NOVEMBER** **Photos for the Bingo Event**
Mary Jane Shomo Memorial Golf Tournament
- DECEMBER** **Holiday Party at the Cortina Inn**
Cancer Program Meeting
Tree Remembrance at the Howe Center

Palliative Care

For the past several years the community cancer center has made a strong formal commitment to palliative care. Initially we collaborated with an outpatient palliative care initiative funded and managed through the Veterans Administration in Albany, New York. This program, called Advanced Illness Coordinated Care (AICC), was designed to assist doctors in the care of their patients with advanced incurable illnesses, particularly advanced cancer. The original design of the program was for doctors in independent practice to refer patients to social workers and nurse practitioners with special interest in palliative care. A series of somewhat scripted encounters helped patients and their caregivers work through the extensive issues of advanced illnesses, decision making and the dying process. A goal of the program was a smooth transition from the time of recognition of the advanced disease to and through the dying process. Another goal of the program was hospice referral. Elizabeth McGrath, NP and Erica Tamblini, CSW have continued this outpatient palliative care program.

The program has been, and continues to be a great success and benefit for our patients. Patients and caregivers feel supported and are given the

time they need to make decisions and come to understanding about their diseases and life. Patients and caregivers have been able to develop a separate relationship with Elizabeth and Erica, using their time in the cancer center to talk, discuss, and plan.

Our inpatient palliative care program, led by Eva Zivitz, RN, has truly taken off during 2006. After an extensive feasibility analysis prior to initiating the inpatient program, the inpatient palliative care program has been widely embraced across the spectrum of medical and surgical specialties. We have analyzed the lengths of stay before and after the palliative care program was initiated. Length of stay has dropped, especially when palliative care consults were initiated upon hospital admission. Furthermore, cost of stay has dropped dramatically since the inpatient palliative care program began. As with the outpatient program, the inpatient palliative care program has given patients and their caregivers an opportunity to think about their lives, diseases and personal wishes in a new and non-judgmental way. The responses from referring physicians and patients have been, and continue to be, overwhelmingly positive.

Support Groups

Our Woman to Woman support group continues to be popular and successful. Meetings are monthly and are open to all women with a cancer diagnosis. Meetings usually last an hour or two depending on content and interest. The group sets its own agenda with the help of our engaging social worker/facilitator, Erica Tamblini, CSW. Financial grants from the Susan Komen Foundation have supported special programs such as Casting for Recovery (*fly fishing*), a Kayaking outing, and several other special events. The Woman to Woman group has active interest in painting and regularly has a series of painting classes led by a local artist.

A couples group has started and has met with enthusiasm. This group has met only once, but we are researching the possibilities of continuing with this special group. A new group for children of parents with cancer will be initiated in 2007.

The Man to Man prostate cancer support group continues to be a vibrant and successful meeting for men and their significant others. This group meets monthly and has made a significant difference for our community. Men feel supported, educated and involved. We applaud this significant contribution.

Acupuncture / Complementary Services

We have had the great fortune of working with Glen Harder, a practitioner of Chinese Medicine and licensed acupuncturist. Glen was formally trained in British Columbia and has family ties to the Rutland area. Donation and grant support allow us to provide Glen's services to cancer center patients. Glen primarily provides acupuncture therapy but also guides patients in lifestyle and personal diet choices.

We have seen wonderfully successful results in many areas of therapy when traditional western treatments are inadequate and/or toxic. Glen has helped many patients with chronic pains and complications of

neuropathy. He has helped patients reduced their need for medications to control symptoms, has improved patients' sleep patterns, and helped with anxiety and digestion.

Our leadership team meets with Glen every other week to review cases, coordinate care, and discuss the complementary practices of eastern and western medicine. Patients are given a pre-visit questionnaire and several post visit questionnaires that allow us some objective measure of the use, value, and need of Glen's services.

Breast MRI Report

2006 marked a milestone in the breast MRI program. In close collaboration with our colleagues in radiology, surgery, and the breast care program office, we imaged our 2000th patient according to the strict guidelines we developed for women at high risk of developing breast cancer or women who needed further clarification of a newly-diagnosed breast cancer. Clearly, this program has been a success. Initially spearheaded by radiologist J.C. Biebuyck, MD and chief MRI technologist Mike Nagar, the program was rapidly embraced by the Rutland community. We started imaging patients in 2001. The ensuing 18 months were a time of rapid learning for all of us. By 2003 we were comfortable with our techniques of both imaging and performing needle localization biopsies in the MRI suite. We began our formal study of breast MRI with Blue Cross and Blue Shield of Vermont in the fall of 2003. This three-year study was completed in 2006. Over 500 women enrolled and continue follow-up under the strict protocol guidelines approved by BCBCVT and the Rutland Regional Medical Center institutional review board. Specifically, women were eligible for MRI if they had features that put them at increased risk for breast cancer. These criteria were based on national and international epidemiologic data presented and accepted in the breast cancer medical community. Women with strong family histories for breast cancer, genetic predispositions to breast cancer, personal histories of breast cancer, abnormal mammograms, or newly diagnoses breast cancer were all eligible for breast MRI.

There were approximately 150 women in each of the three categories: family history, personal history, and abnormal mammogram. Approximately 75 women were enrolled with newly diagnosed breast cancers based on stereotactic biopsy or fine needle aspiration. As expected, the category with the fewest new breast cancers was the family history group (1%). Approximately 5% of women with a personal

history of breast cancer who had a normal mammogram had a biopsy proven MRI discovered ipsilateral or contralateral breast cancer. MRI was particularly useful for women with abnormal mammograms. For women with category “0” (*BI-RADS classification*) mammograms, our study required a biopsy if a biopsy would normally have been performed based on the mammogram findings even if the pre-biopsy MRI suggested the absence of cancer. 100% of the category “0” cases which underwent biopsy and had a negative MRI were proven to not have cancer. We continue to follow these cases and will follow them indefinitely to determine the true negative rate for breast MRI. For patients with category 4 or 5 mammograms (*BI-RADS classification*) breast MR was particularly useful in predicting accurate size of the index cancer lesion. Dr. Lovett and his research assistant were able to prove the significant difference between the size predicted by mammogram, breast MRI and the correlation with the final pathologic specimen. It is clear that a better understanding of breast lesion size will lead to better preoperative planning and fewer cases of positive margins requiring second breast surgeries. This saves patients and the health system time, risk, and money without compromising information.

In 2006, as a result of our collaboration with Blue Cross and Blue Shield of Vermont regarding breast MRI in high risk patients, BCBSVT issued specific new guidelines for their covered patients. These criteria included the criteria of our protocol but was expanded based on additional data regarding family history and risk, such as presence of bilateral breast cancer, male breast cancer, and family history of ovarian cancer.

We have enjoyed our close relationship with BCBSVT and are proud of our ability to collaborate at a time when there is an increasing level of tension in health care over access, cost and appropriate delivery of care.



Tumor Registry

Cancer Registrars capture a complete summary of the history, diagnosis, treatment, and disease status for every cancer patient. Registrars' work leads to better information that is used in the management of cancer and, ultimately, cures. Tumor Registry at Rutland Regional Medical Center is responsible for maintaining a database of all patients diagnosed and/or treated with cancer at Rutland Regional. Our database contains information dating back to 1978 when the registry began. Our database includes information about our patients' healthcare from the time of diagnosis and treatment along with lifetime follow-up. In 2005, the number of cases added to the registry totaled 443. There are currently 7,158 cases in the registry with around 2,811 under active follow-up. As an approved cancer program by the Commission on Cancer, all cases from our reference date of January 1, 1992 need to be followed on an annual basis.

The Registry has been participating in the Vermont Cancer Registry's (VCR) bi-monthly teleconferences. These calls give the VCR registry the opportunity to educate and answer questions from Vermont hospitals' registries all at one time. This year's topics included data quality, collaborative staging, and the new Multiple Primary & Histology Coding Rules. In June, the Vermont registrars joined registrars from Maine and New Hampshire for a Tri-State Cancer Conference. Presentations were held on ovarian cancer, hematopoietic malignancies, melanoma, and colon cancer.

Information collected by the registry is reported on a weekly basis to the VCR. The VCR is a central bank of data of all Vermont cancer cases. The VCR consolidates data submitted by multiple hospitals into one complete record. This data is then reported to both the Centers for Disease Control (CDC) and North American Association of Central Cancer Registries (NAACCR). This information is important as it allows for the study of cancer trends and improvement of cancer education and prevention. The most common cancers diagnosed in Vermont women are breast, colon, lung, uterine, and melanoma. These account for over 65% of new cases. For Vermont men the most common cancers are prostate, lung, colon, bladder, and prostate. Cases need to be reported to the VCR within 180 days of the date of first contact with the patient. In 2006, our number of days to report has decreased considerably due to submitting data more often and concentrating on abstracting cases.

Another registry activity is a new procedure for placing staging forms on the medical records. This has increased the accuracy of the correct forms being added and the percentage of forms filled out. The registry also participated in the NAACCR Webinar Series. Eight Webinars were held, each focused on a specific site, such as melanoma or lung cancer. Topics included anatomy, histology, staging, and coding of cancer cases. In the fall we began Beta testing new software for our software provider, IMPAC. This new version of the software combined the company's two registry softwares MRS and Precis-Hospital. The new software allows for many more reporting and query options.

Cancer Incidence at RRMC 2006

Primary Site	Cases	Male	Female
Anus & Anal Canal	1	0	1
Base of Tongue	1	1	0
Bladder	24	14	10
Brain	4	0	4
Breast	93	0	93
Bronchus & Lung	72	38	34
Cervix Uteri	3	0	3
Colon	34	16	18
Connective & Other Soft Tissue	3	1	2
Corpus Uteri	22	0	22
Esophagus	5	3	2
Eye & Adnexa	0	0	0
Gallbladder	1	0	1
Gum	0	0	0
Heart/Mediastinum/Pleura	0	0	0
Hematopoietic & Reticuloendo System	15	9	6
Hypopharynx	1	0	1
Kidney	3	2	1
Larynx	5	4	1
Liver & Intrahepatic Bile Duct	4	3	1
Lymph Nodes	14	10	4
Nasal Cavity & Middle Ear	0	0	0
Nasopharynx	1	1	0
Oropharynx	1	1	0
Other Endocrine Glands	1	0	1
Other Female Genital Organs	1	0	1
Other Major Salivary Glands	0	0	0
Other Mouth	4	3	1
Other Parts Of Biliary Tract	0	0	0
Other Tongue	1	1	0
Ovary	3	0	3
Palate	1	0	1
Pancreas	9	6	3
Parotid Gland	0	0	0
Prostate Gland	74	74	0
Pyriiform Sinus	1	1	0
Rectosigmoid Junction	2	1	1
Rectum	8	5	3
Renal Pelvis	0	0	0
Retroperitoneum & Peritoneum	1	0	1
Skin	8	4	4
Small Intestine	1	1	0
Stomach	2	1	1
Testis	0	0	0
Thymus	1	1	0
Thyroid Gland	9	1	8
Tonsil	3	2	1
Unknown Primary Site	7	3	4
Uterus	0	0	0
Vulva	1	0	1
Total All Sites	443	206	237

* This table includes patients initially diagnosed at Rutland Regional or those patients initially diagnosed elsewhere and initially treated at Rutland Regional Medical Center.

Fever and Neutropenia

The 2005 annual report reviewed our data on patient admissions for fever and neutropenia. Five years of data were reviewed and analyzed. Noteworthy were the small numbers of patients who were admitted with this diagnosis. In addition, there were no deaths associated with fever and neutropenia diagnosis. For 2006, we have again reviewed our fever and neutropenia admissions. There were only two admissions throughout the entire year with a principal diagnosis of fever and neutropenia. This includes all cases where sepsis or infection was a part of the admission diagnosis. Again, there were no deaths related to fever or neutropenia during 2006.

Fever and neutropenia diagnoses are significant for a variety of reasons. First, the admission leads to a hospital stay for an otherwise independent outpatient. The fear and anxiety of a hospital stay are omnipresent, even if necessary for patient safety. Second, the risk of superinfections due to nosocomial exposure raises the risk to patients even when patients are placed in reverse isolation and nurses and hospital staff use universal infection precautions. Third, patients with fever and neutropenia, by definition, often have a higher than average acuity level. The administration of multiple medications increases the risk of clerical and pharmacy error, further putting patients at risk. Finally, the admission for fever and neutropenia often delays or otherwise affects decisions about the present, active treatment of the patient with cancer. Questions about the value of continued treatment, a need to change treatment, and confidence in the treating team are but a few of the issues that inevitably arise.

We employ several practice policies which have been successful in minimizing admissions for fever and neutropenia. First, our nurses take a very active and involved interest in each and every patient's case. Their awareness of patients and their honed "nursing instincts" are invaluable. Our nurses educate our patients even before they start chemotherapy. We encourage our patients to take an active role with us in their care. We have an open dialogue with our patients and their caregivers which often identifies complications of treatments or changes in the status of an illness before it has gotten out of control. Second, we check blood counts on a regular basis. This information helps both us and our patients maintain an awareness of their health status. Third, we use prophylactic fluoroquinolone therapy. Published literature in the medical oncology community has proven the reduction in infections with this simple measure while patients are most vulnerable. Finally, we talk with our patients about appropriate treatment. Patients who are debilitated from their cancers, have complications from comorbid conditions and, for a variety of other reasons, would not tolerate treatment well are all at risk for complications of further anti-cancer therapy. We partner with our patients to understand and decide the safest times both for treatment and careful observation.

Our patients' safety is our prime concern during treatment. By minimizing admissions for fever and neutropenia, we keep our patients' treatment on track and appropriate.



Support Staff

The unsung heroines of the cancer center are the support staff. Our pool of secretaries and administrative assistants handle every job, large or small, with grace and kindness. Our office staff has some of the most complicated patient orders. Frequently they are coordinating laboratory blood tests, office visits with doctors, several hour long treatments and organizing that around a series of radiology tests. And this happens day in and day out without a hitch. Our administrative staff meets our patients on the way into the office and sends them on their way at the end of a visit with cheery hellos and goodbyes. Patients feel reassured that their appointments will happen on time and at the most convenient times possible. We would be lost without the expertise of our office staff and we applaud them for all they do.

Clinical Research

We continue to offer state of the art clinical research protocols sponsored by cooperative groups and pharmaceutical companies. Both of these complement our largest study, the breast MRI study in collaboration with Blue Cross and Blue Shield of Vermont. We have approximately 30 protocols open which span the spectrum of phase II and phase III studies. Most of these studies are comparing existing “first choice” therapies with or without the addition of a study drug. We also have close collaborations with our colleagues in Boston at a variety of institutions, Dartmouth Hitchcock Medical Center, Fletcher Allen Health Care in Burlington, Vermont, and the research cooperative group in the capital district of Albany, New York. Patients are encouraged to consider protocol enrollment when appropriate and have easy access to referral sites.

Initiated in 2006 and planned for ongoing evaluation and analysis, will be an outcomes measure program for major disease sites such as colon/rectal cancer, breast cancer, lung cancer, and prostate cancer. We want to ensure that we offer and follow through with care that meets national standards using the statistical evaluation of our own cases here in Rutland.

Oncology Pharmacy

As required by the Joint Commission on Accreditation of Healthcare Organizations, we have a fulltime pharmacist in the cancer center. Clare Coppock has taken her responsibilities seriously but also with great enthusiasm and a flair for coordinating her services with the larger cancer center. Although the bulk of Clare’s job is focused on mixing and preparing medications for our cancer patients, Clare’s daily activities go far beyond this “chore”. Clare serves as an incredible educational resource for nurses and providers, advising us on potential harmful drug interactions as well as finding more efficient and cost effective approaches to medical cancer care. Clare is always “up” on the latest advances in new drug approvals and works diligently with our hospital vendors and local pharmacies to keep new drugs available for our patients. Clare’s expertise is invaluable. We couldn’t do it without you, Clare!

Cancer Program Report Radiation Oncology



In 2006, we have continued to improve services in Radiation Oncology at Rutland Regional Medical Center.

We have concentrated these efforts in technologies which will benefit men with prostate cancer. Prostate cancer affects many men as they age. Beginning in their 40’s and onward, men are all at risk for this disease. Two of the radiotherapy treatments for prostate cancer are external beam radiotherapy and prostate seed implant.

Dr. Ernest Bove and I have now traveled to the Seattle Prostate Institute at the Swedish Hospital to learn this technique. We are in the process of purchasing this equipment to perform this technique and are working with the Prostate Clinic and Surgical Services to get this modality available for the first time in Rutland.

With external beam radiotherapy we have increased accuracy of Intensity Modulated Radiotherapy in planning the prostate treatments with IGRT (*Image-Guided Radiation Therapy*). We introduced this technique to Vermont in 2004. We now have brought Image-Guided Radiotherapy to Vermont and were the first institution to offer it in the State. Image Guidance pinpoints the exact location of the structures within the body receiving radiotherapy and makes the minute position changes necessary to make the most use of the accuracy of IMRT. Men are already benefiting from Image Guidance in their treatment and the technique is being used in treatment of other malignancies.

In clinical research I have looked into MRI scanning for breast carcinoma over the past year. A local college student, Jennifer Stedman, and I have examined women diagnosed with breast cancer at Rutland Regional, who have had pre-operative MRI and mammogram studies. We found the MRI to be a more accurate predictor of size of the breast carcinoma than mammography. Our study appears in this report and was presented at the Vermont Breast Cancer Conference as a poster exhibit in 2006.

Again, in radiation oncology, we have instituted quality improvements, which we feel will help the patients of Rutland Regional as this hospital continues in its quest to be the “Best Community Hospital and Health System in New England”.

Sincerely,



Richard Lovett, MD
Radiation Oncology

Rutland Regional's Bone Marrow Donor Program

Our Mission: *There is never a cost to potential donors to join the National Registry through our program, and we will turn no potential donor away for lack of funding.*

The Rutland Regional Marrow Donor Program was established in November 1998. Rutland Regional is currently the only hospital in New England with this type of program. Since May 2005, 550 potential donors have been added, 48 of them minorities for which there is a critical need. In total, over 1200 potential donors added to the National Registry since 1998.

Growth: One drive per year from 1998 – 2002

2002 – increased to two drives held in Rutland, at the request of the New England Marrow Donor Program due to the large number of people called back for more testing as potential donors.

2004 – added an affiliate group, The Champlain Valley Marrow Donor Program and increased to four drives per year, two in Rutland, two in Burlington

2005 – added another affiliate group, The Windsor County Marrow Donor Program and increased to seven drives – two in Rutland, two in Burlington, one in Springfield, one in Woodstock, one in Manchester

2006 – Be Someone's Hero! campaign – seven drives two in Burlington, two in Rutland, one in Montpelier, one in Fair Haven, one in Castleton. Changed from blood test to using the buccal cheek swab, enabling us to hold drives at community events.

2007 – Drive For Hope! campaign – three drives scheduled so far:

- Oct 21st in Burlington
- Oct 26th in Rutland at the Asa Bloomer Building
- Dec 19th in Rutland at the Paramount – this drive is in conjunction with the American Red Cross Gift of Life Marathon and will possibly result in between 300 – 400 potential donors

Discussions are currently being held with area colleges (*CSC, GMC, Champlain College, and UVM*) to hold drives on their campus in the October – December time frame. Discussions are currently being held with several area businesses to hold drives at their locations. Spring drives will be held in Burlington, Rutland and Windsor County – dates are not confirmed yet however. Discussion is in process to hold another drive in Montpelier when the legislature is in session – no date confirmed yet.

Cost for the samples to be typed: between \$65-\$85 per donor. We do not have a budget, this program exists on donations and fund raising. The Rutland Regional Marketing Dept covers the cost of our advertising. We have just received notification that the Marrow Donor Program at Rutland Regional has been nominated for the NMDP Allison Atlas Award by the New England Marrow Donor Program. While this is not a monetary award, we are very honored to be shown recognition and appreciation by the National Marrow Donor Program.

Fundraising/Donations

We are fortunate to be surrounded by a community that appreciates and supports the cancer center and cancer program in Rutland. We are grateful to all of the individual donors who generously give in memory of special friends and family who have had cancer. We, at the cancer center, cannot thank you enough for your ongoing support.

In addition, we have been honored by the consistent fundraising by local groups and organizations who have kept the memory of loved ones alive and the hope for successful treatments high in their hearts.

These generous benefactors to our programs include:

Fair Haven Eagles/Aires and all their friends and supporters, Kim Woodard and Friends annual motorcycle ride to Lake George, Dick Currier Family and Friends annual softball tournament, Family and Friends of Eleanor Laplante, Mary Wells Memorial 5K Run, Castleton Elementary School, Carol and Marguerite Comstock, Roy and Claire Rotella and Family.

Grants

We have been proud recipients of Komen Foundation and Rutland Regional Auxiliary grants during 2006. Money has been used for support of the Woman to Woman support group, the Breast Care Program,

patients in need, and educational activities for staff. We plan to continue our grant writing efforts to help defray the endless list of projects and patients in need.

The Community Cancer Center at Rutland Regional offers hope and healing to cancer patients and their families through:

- Medical oncology with state-of-the-art therapies, including chemotherapy, monoclonal antibody therapy and comprehensive supportive care
- Radiation oncology, including expert 3-D treatment planning and radiation treatment with a state-of-the-art linear accelerator
- The Breast Care Program, addressing women's needs surrounding breast cancer and other breast health issues
- An experienced, skilled and sensitive care team (*consisting of one full-time, Board-certified oncologist, one full-time, Board-certified radiation oncologist, a nurse practitioner, a physician assistant, five oncology certified nurses, three radiation therapists, clinical social worker and support staff*) that provides personalized, one-on-one attention and support
- Cancer screenings and educational programs, and support groups
- Federally funded research through the National Cancer Institute



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