

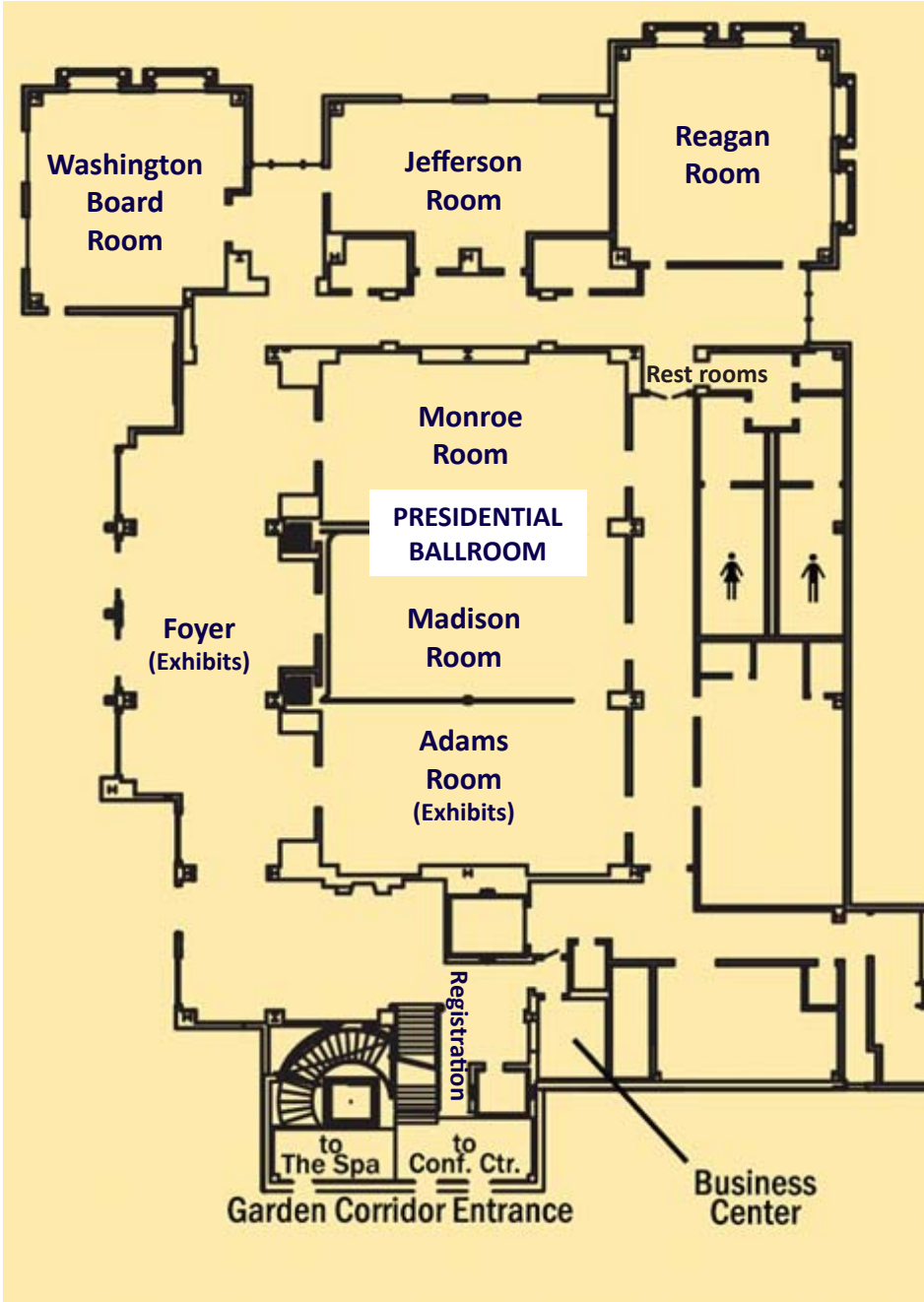
2011 ANNUAL MEETING



Program & Abstracts

**BRETTON WOODS, NH
OCTOBER 28-29, 2011**

CONFERENCE CENTER LAYOUT



Grand Ballroom is upstairs on the Lobby Level

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Welcome to Bretton Woods and the 2011 NNECOS Annual Meeting!

Thank you for joining us for our annual meeting at the beautiful Omni Mount Washington Hotel. In addition to the fabulous slate of speakers presenting the latest in clinical advances and practice updates, we invite you to also take advantage of the opportunity to network with colleagues from across the region. Together, professionals must participate in the political, economic, and scientific debates that challenge the cancer care community nationwide.

Please be sure to take the time to visit with the representatives of the companies who have helped to support our society throughout the year. Exhibits and refreshments will be located in the Presidential Foyer and Adams Room.

At the conclusion of the meeting, we ask that you complete and submit your evaluation, allowing you to obtain educational credit, and providing feedback to help shape future educational events.

2011 Annual Meeting Planning Committee

*Denis Hammond, Michael Fisch,
Andy Hertler, Steve Larmon
Lori Aubrey, Marty Byrne, Angela Gibbs*



FRIDAY AGENDA

12:00 - 1:00 PM	LUNCHEON BUFFET Seating in MADISON EXHIBITS	FOYER FOYER & ADAMS
1:00 - 2:00 PM	CONCURRENT BREAKOUTS Recognition And Screening of Distress in Patients with Cancer <i>Kathleen McBeth, MA , Cancer Patient Support Program Coordinator Fletcher Allen Health Care</i>	JEFFERSON
	Are Anthracyclines a Necessary Component of Adjuvant Chemotherapy For Breast Cancer? <i>Michael Hassett, MD, MPH, Dana-Farber Cancer Institute Assistant Professor of Medicine, Harvard Medical School</i>	MONROE
2:00 - 2:25 PM	BREAK/EXHIBITS	FOYER/ADAMS
2:25 - 3:25 PM	CONCURRENT BREAKOUTS Oral Chemotherapy: Tools for Safety And Compliance <i>Steven L. D'Amato, RPh, BCOP Maine Center for Cancer Medicine</i>	MONROE/MADISON
	Alternate Radiation Treatment Schedules for Breast Cancer <i>Ruth Heimann, MD Vermont Cancer Center</i>	JEFFERSON
3:30 - 4:30 PM	GENERAL SESSION Cancer Care, What Is It Worth? <i>Michael Hassett, MD, MPH Dana-Farber Cancer Institute Assistant Professor of Medicine, Harvard Medical School</i>	MONROE/MADISON
4:30 - 5:00 PM	GENERAL SESSION Commission On Cancer 2012 Update: Investing In Quality Patient Care <i>Melanie Feinberg, BA, Maine Medical Center</i>	MONROE/MADISON
5:00 - 6:45 PM	COCKTAIL RECEPTION/ POSTER SESSION	GRAND BALLROOM
6:45- 8:45 PM	DINNER PROGRAM ASCO: The CPC, State Affiliates and Washington Update <i>Daniel M. Hayes, MD, Maine Center for Cancer Medicine</i>	GRAND BALLROOM
8:45 - 9:15 PM	BUSINESS MEETING	GRAND BALLROOM

Call for Educational Meeting Planning Committee Volunteers!

Enjoying this year's meeting? Have ideas to help make next year's meeting even better?

NNECOS seeks to offer educational programs providing relevant, meaningful, useful content for oncology professionals across the region, in both the private practice and hospital settings. Representation from professionals involved in oncology care in the diverse settings of northern New England is essential to meeting this goal.

NNECOS needs you! Our ability to host two great educational meetings a year is entirely dependent upon our outstanding member volunteers! All Active, Associate, and Fellows members are eligible to participate on meeting planning committees.



Little Time? No Worries!

Conference planning is conducted via teleconference at a mutually convenient time. Calls typically last less than an hour.

If you'd like to lend your time and talents to shaping future NNECOS educational meetings, please email info@nnecos.org to volunteer.

SATURDAY AGENDA

6:30 -8:30 AM	PLATINUM ROUNDTABLE <i>BY INVITATION ONLY</i>	REAGAN
7:00 AM - 2:00 PM	POSTERS ON DISPLAY	JEFFERSON
7:30 - 9:00 AM	BREAKFAST BUFFET/EXHIBITS	FOYER/ADAMS
8:45 - 9:45 AM	FEATURED PRESENTATION Integrating End of Life Care into the Treatment Plan for Incurable Cancers <i>Joseph A. Greer, PhD, Massachusetts General Hospital Cancer Center</i>	MONROE/MADISON
9:50 - 10:50 AM	CONCURRENT BREAKOUTS Antiemetics, Pharmacology and Personalized Medicine <i>Steven M. Grunberg, MD, University of Vermont Hematology/Oncology</i>	MONROE/MADISON
	Axillary Staging for Breast Cancer Patients <i>Lisa Rutstein, MD, Maine Surgical Care Group</i>	REAGAN
10:50 - 11:20 AM	REFRESHMENT BREAK/EXHIBITS	FOYER & ADAMS
11:20 AM - 12:10 PM	ABSTRACT PRESENTATION SESSION <i>David Cranmer, BA, Vermonters Taking Action Against Cancer</i> <i>Amanda Lamb, ScM, Maine Medical Center</i> <i>Monic Roengvoraphoj, Dartmouth-Hitchcock Medical Center</i>	MONROE/MADISON
12:10 - 1:10 PM	LUNCH/EXHIBITS Remarks by President-elect Tom Openshaw, MD	BALLROOM / FOYER
1:15 - 2:15 PM	GENERAL SESSION Exercise and Cancer: Risk Reduction and Symptom Amelioration <i>Amy Litterini, PT, DPT, Center for Cancer Care at Exeter</i> NNECOS Research Study Project	MONROE/MADISON
2:20 - 2:50 PM	GENERAL SESSION The NNECOS Collaborative Improvement Network <i>Andrew A. Hertler, MD, FACP</i> <i>Harold Alford Center for Cancer Care</i>	MONROE/MADISON
3:00 - 4:00 PM	CONCURRENT BREAKOUTS Melanoma 2011: New Approaches to Care and Treatment <i>Marc S. Ernstoff, MD, DHMC - Norris Cotton Cancer Center</i>	MONROE/MADISON
	Stereotactic Body Radiotherapy for Early Stage Lung Cancer: Current State and Future Directions <i>Andrea B. McKee, MD, Radiation Oncology Associates</i>	REAGAN

Continuing Education

Educational Objectives

After attending the conference, participants should be able to:

- Apply advances in scientific and translational research in the care of their patients; (*knowledge, competence, performance, patient outcomes*);
- Evaluate the role of new diagnostic techniques and therapeutic strategies as applied to the care and treatment of patients with cancer (*knowledge, competence, performance, patient outcomes*);
- Implement new practices or review existing ones to improve the quality of care delivered, based upon knowledge gained at the 2011 NNECOS Annual Meeting; (*knowledge, competence, performance, patient outcomes*);
- Discuss legislative and regulatory issues that have an effect on cancer care and oncology practice in our region (*knowledge*);
- Develop and implement strategies to improve communication within practices to enhance patient care; (*knowledge, competence, performance, patient outcomes*);
- Enhance patient care through collaboration with other practices within the region; (*knowledge, competence, performance, patient outcomes*);
- Recognize the importance of an integrated multi-disciplinary system of care for the patient with cancer (*knowledge*).

Target Audience - CME

This program is directed toward a broad physician audience including hematologists, medical oncologists,

surgical oncologists, and radiation oncologists with both clinical and non-clinical responsibilities in community, hospital, and academic settings.

Educational Methods

Lectures, Panel Discussions, Posters Sessions

Evaluation

A course evaluation form will provide participants with the opportunity to comment on the value of the program content to their practice decisions, performance improvement activities, or possible impact on patient health status. Participants will also have the opportunity to comment on any perceived commercial bias in the presentations as well as to identify future educational topics.

THE UNIVERSITY OF TEXAS

MD Anderson Cancer Center

Accreditation/Credit Designation

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of The University of Texas MD Anderson Cancer Center and the Northern New England Clinical Oncology Society. The University of Texas MD Anderson Cancer Center is accredited by the ACCME to provide continuing medical education for physicians.

The University of Texas MD Anderson Cancer Center designates this live activity for a maximum of 9.75 *AMA PRA Category 1 Credits™*. Physicians should claim only credit commensurate with the extent of their participation in the activity.

The presentations, *Recognition and Screening of Distress in Patients with Cancer; Cancer Care, What is it Worth?; Integrating End of Life Planning into the Treatment Plan for Incurable Cancers; Antiemetics, Pharmacology and Personalized Medicine*, and *Exercise and Cancer: Risk Reduction and Symptom Amelioration*, have been designated by The University of Texas MD Anderson Cancer Center for 4.00 AMA PRA Category 1 Credits™ in medical ethics and/or professional responsibility.

CME Certificates and Attendance Verification Certificates

Certificates awarding *AMA PRA Category 1 Credit™* or certificates documenting attendance will be distributed to participants when an individual departs

the conference. To obtain a CME certificate, physicians must submit a completed evaluation questionnaire and a *CME Verification Form*.

Upon request, a record of attendance (certificate) will be provided on-site to other health care professionals for requesting credits in accordance with state nursing boards, specialty societies, or other professional associations.

Nursing CEUs: This activity has been submitted to the Oncology Nursing Society for approval to award contact hours. ONS is accredited as an approver of continuing nursing education by the American Nurses Credentialing COA.

THE UNIVERSITY OF TEXAS MD ANDERSON CANCER CENTER DISCLOSURE POLICY FOR PROGRAM CHAIR(S), PLANNING COMMITTEE MEMBERS, TEACHERS, OR AUTHORS AND CME ACTIVITY REVIEWERS

The Accreditation Council for Continuing Medical Education has announced standards and guidelines to insure that individuals participating in CME activities are aware of program chair(s), planning committee member, faculty/teacher/author, CME activity reviewer relationships with commercial interests that could potentially affect the information presented. The University of Texas MD Anderson Cancer Center has implemented a process whereby everyone who is in a position to control the content of an educational activity must disclose all relevant financial relationships with any commercial interest.

The University of Texas MD Anderson Cancer Center has, through a formal review process, resolved all conflicts of interest prior to this activity. For information on this process, please contact the Department of CME/Conference Management at 713/792-5357.

DISCLOSURE INFORMATION

FACULTY / PROGRAM PLANNING COMMITTEE MEMBERS / CME ACTIVITY

REVIEWERS

Faculty, Program Planning Committee Members and CME Activity Reviewers/ Approvers have financial interests, arrangements or affiliations with the manufacturer of any product or devices to be discussed, or who may financially support this CME activity, as indicated below. An asterisk (*) indicates that the faculty's presentation will include discussion of investigational or off-label uses of a product.

FACULTY

Steven L. D'Amato, R.Ph. BCOP
Relationship not relevant to content

- Steven M. Grunberg, MD
- *Pros and cons of therapeutic options will be discussed*
 - *Multiple therapeutic options/protocols will be discussed*
 - *Content of presentation will be based on best available evidence*

Ruth Heimann, MD, PhD
Relationship not relevant to content

Andrew A. Hertler, MD, FACP
Focus on presentation away from relationship

COMMERCIAL INTEREST

Speaker's Bureau: Amgen, Eisai, Merck, Genentech, Celgene

Paid consultant: Helsinn; Tesoro

Speaker's Bureau: Merck

Honoraria: Merck

Membership on advisory committees or review panels, board membership, etc.:

Archimedes Pharma, Merck

Ownership interest: Merck

Grant/research support: Elekta

Honoraria: Elekta

Grant support: ASCO State Affiliate Grant

PLANNING COMMITTEE MEMBERS

Steve Larmon, MD
Denis B. Hammond, MD

COMMERCIAL INTEREST

Stock Ownership: Bristol-Myers Squibb

Employment: NH Oncology

CME ACTIVITY/REVIEWER/APPROVER

Issa Khouri, MD

COMMERCIAL INTEREST

Grant /research support: Cephalon, Celgene, Millennium

DISCLOSURE INFORMATION

FACULTY / PROGRAM PLANNING COMMITTEE MEMBERS / CME ACTIVITY

REVIEWERS (CONT.)

Faculty, Program Planning Committee Members and CME Activity Reviewers/ Approvers have indicated no financial interests, arrangements or affiliations with the manufacturer of any product or devices to be discussed, or who may financially support this CME activity.

FACULTY

David Cranmer

Marc Ernstoff, MD*

Melanie Feinberg BA

Joseph Greer, PhD

Michael Hassett MD

Daniel M. Hayes, MD

Amanda Lamb, ScM

Amy Litterini PT, DPT

Kathleen McBeth MA

Andrea McKee, MD

Monic Roengvoraphoj, MD

Lisa Rutstein, MD

PLANNING COMMITTEE MEMBERS

Lori Aubrey, BS

Marty Byrne, BSN, RN

Michael J. Fisch, MD

Angela R. Gibbs, RN, MSN, OCN

Andrew A. Hertler, MD, FACP

CME ACTIVITY REVIEWERS/APPROVERS

Gregg Staerkel, MD

Stephen Tomasovic, PhD

Paul Walker, MD

NOTICE

All statements and opinions contained herein are solely those of the individual speakers and may not reflect those of The University of Texas MD Anderson Cancer Center.

The University of Texas MD Anderson Cancer Center does not endorse the commercial products, equipment, or services presented by program supporters/exhibitors.

Annual Business Meeting

Friday, October 28, 2011

8:45 PM

AGENDA

- 1. Call to order – *Dr. Hammond***
- 2. Committee Reports – *Dr. Hammond***
 - a. Membership – *Dr. Openshaw*
 - b. Finance – *Dr. Larmon*
 - c. Nominating – *Dr. Crow*
 - d. Website – *Dr. Briccetti*
- 3. Member Educational Activities – *Dr. Hammond***
 - a. 2012 Spring Meeting - Tuesday May 15, 2012
 - b. 2012 Annual Meeting - October 29-20, 2012
 - c. Invitation to Join Planning Committees
- 4. Election of Board of Directors – *Dr. Hammond***

As presented by Nominating Committee Chair – *Dr. Crow*
- 5. Other business – *Dr. Hammond***
- 6. Adjourn**

NNECOS 2011 Annual Meeting Abstracts: Volume 6

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NNECOS 2011 Annual Meeting Abstracts

The Northern New England Clinical Oncology Society (NNECOS) is pleased to present the following abstracts from across the region and beyond in the fifth year of the abstract program. These abstracts have been reviewed by NNECOS' abstract committee and approved by the NNECOS Board of Directors for presentation at this year's meeting. Thanks to all who took the time to share information and ideas with colleagues through this means. We'll look forward to another group of abstracts for presentation at our 2012 Annual Meeting.

Case Report: Novel deletion causing variant APL responsive to ATRA.

M. Alam, J. Sprague, M. Tang
University of Vermont

Background: A characteristic feature of APL is presence of translocation t(15:17) (q22;q12). This is present in 95-98% of cases of APL and 5-8% of cases of AML. This rearrangement results in encoding of a chimeric protein PML-RAR α . The PML-RAR α transcript is considered pivotal in pathogenesis of APL and the detection of transcript is considered essential to confirm the diagnosis of APL and correlates with response to use of all-trans retinoic acid (ATRA)

Methods: Here we report a case of APL that did not harbor the classic t(15:17) (q22;q12) by Fluorescent in situ hybridization(FISH).

Results: A 74 year old man was hospitalized in March 2011 with WBC of 220 K/cmm, platelets of 50 K/cmm and hemoglobin of 9g/dl. His bone marrow biopsy showed a markedly hypercellular bone marrow with proliferation of early myeloid forms with dense organophilic cytoplasmic granulation. PML-RAR α fusion probe did not show evidence of PML-RAR α fusion, however signal on the RAR portion of the PML-RAR α appeared diminished. Further FISH analysis to look for cytogenetic abnormalities was done using Vysis LSI RAR α dual break apart rearrangement probe. The results showed that 94.5% of nuclei had an abnormal RAR α gene signal with loss of the 3' RAR α portion. This is consistent with an atypical deletion that disrupts the RAR α gene region.

Conclusions: He was started on treatment with ATRA at 90mg/day divided in two doses. Fourteen days after treatment WBC count was noted to be 5 K/cmm and platelets 486 K/cmm. Repeat Fish analysis showed only 6% of nuclei with loss of the 3' RAR α signal. Quantitative Polymerase Chain Reaction (qPCR) showed no PML-RAR α transcripts. Twenty-one days after treatment FISH detected 3' deletion of the RAR α gene in only 2% of cells.

Surviving Cancer in Vermont: What We Are Learning From Survivors

D. Cranmer, B. Geller

Vermonters Taking Action Against Cancer, University of Vermont

Background: The Vermont Cancer Survivor Community Study was an NCI-funded project written by cancer survivors and researchers at the University of Vermont. The goal was to establish a cancer survivor registry in Vermont.

Methods: In the first phase, we mailed invitations to participate to 6,030 cancer survivors, 3,302 answered and 2,005 agreed to participate in the registry. In the second phase we developed and conducted a 12-page survey to gather information on survivors' needs and identify unmet needs. The purpose is to use the research to improve services and support for cancer survivors.

Results: 1,668 people (83 percent) responded. Preliminary results showed that low need groups tended to be male, likely to be over 70, diagnosed with melanoma. High need groups tended to be females, under 60, diagnosed at late stage, treated with over 4 treatments. Looking at unmet needs, 30 percent said they had unmet needs in the area emotional, social and spiritual support and 25% said they had unmet needs for information, specifically on side-effects and late-term effects.

Conclusions: Cancer Survivors are willing to participate in a registry and be contacted for research. The results of the survey will be shared with the participating communities, state policy makers, and cancer-related programs. Vermonters Taking Action Against Cancer (VTAAC), the state cancer coalition is convening a Survivorship Collaboration Workgroup to implement the findings from this study. Additional research is necessary to learn how to engage underserved populations in survivorship research.

Maine Medical Center NCI Community Cancer Centers Program: Progress in Improving Access to Clinical Trials

E. Emery¹, C. Ewan-Whyte¹, L. Lucas, M. Feinberg¹, K. Blackburn¹, A. Gibbs¹, B. Chase², B. Grillo¹, J. Hedlund^{1,2}, E. Larson¹, S. Meisfeldt¹

¹Maine Medical Center, ²Maine Center for Cancer Medicine

Background: Clinical trials are the recognized engine for progress in cancer care, but participation by adult patients has been historically low. Less than 5% of adult cancer patients participate in clinical trials and this proportion is even lower for racial and ethnic minorities and other medically underserved groups. Recognizing this, the National Cancer Institute (NCI) made Clinical Trials and Disparities the prominent pillars in their Community Cancer Centers Program (NCCCP), a program launched in 2007 and joined by Maine Medical Center (MMC) in 2010. A major goal of MMC's NCCCP is to increase clinical trial participation, particularly among the medically underserved.

Methods: With guidance from the NCI, Maine Medical Center Cancer Institute set out to implement a number of initiatives to increase access to and participation in clinical trials, with a specific focus on those patients in Maine with healthcare disparities, particularly immigrant/refugee, rural, low-income individuals, and seniors.

Results: Initiatives undertaken in year 1 of the program included: 1) assessing/addressing systemic barriers to clinical trial participation; 2) developing a low-literacy clinical trial educational brochure for patients; 3) assessing/monitoring the number of disparate clinical trial patients served through demographic data collection; 4) increasing transportation and housing resources for patients through local/regional partnerships; 5) promoting trial access through a Mid-Coast-based "system navigator" and two Portland-based cross-cultural navigators; 6) conducting clinical trial gap analyses to better match trial offerings to patient populations; 7) supporting growth of scientifically-compelling, investigator-initiated studies through collaborations with MMC Research Institute and The Jackson Laboratory; 8) increasing visibility/accessibility of clinical trials for referring clinicians through a website and email newsletter; 9) strengthening the capabilities of MMC to bank cancer tissue for research studies; 10) partnering with Dana Farber and Tufts to improve access to their Phase I trials; 11) undertaking construction of an electronic clinical trial management system. Early enrollment numbers indicate that the number of patients enrolled in NCI-sponsored trials increased since the program began, as did the number of patients enrolled in investigator-initiated studies. This has led to an enrollment rate increase from 7.8% in 2009 to 8.6% in 2010 among adult patients, and an overall enrollment rate increase from 9% to 11%.

Conclusions: Engagement with the NCI and our participation in the Community Cancer Centers Program has significantly enhanced our Cancer Clinical Trials Program and has resulted in the development of several important initiatives that will benefit our cancer patients and our research mission. The accrual gains observed are bound to continue climbing in 2011 as the program and all its initiatives continue to mature.

Hitting two birds with one stone: Targeting the B-cell in a patient with abdominal cramps, splenomegaly, and pancytopenia.

D. Lam, N. Levy, J. Nickerson, F. Lansigan*

*senior author

Dartmouth-Hitchcock Medical Center

Background: An elderly woman initially complained of recurring episodes of crampy abdominal pain with nausea lasting 4-6 weeks without constitutional symptoms. She then developed massive splenomegaly with pancytopenia. After a circumstantial workup spanning two years, she was given the uncommon diagnosis of acquired angioedema due to deficiency of the inhibitor of the first complement component (C1-INH). Hematology evaluation additionally revealed a splenic marginal zone lymphoma (SMZL).

Methods: This patient was treated with rituximab 375mg/m² weekly x 4 doses.

Results: This resulted in the resolution of splenomegaly, normalization of her blood counts, and clinical remission of acquired angioedema with no recurrence of abdominal symptoms.

Conclusions: Acquired angioedema is a result of B-cell proliferation that recognizes C1-INH and leads to the proliferation of autoreactive B-cell clones and the production of autoreactive antibodies. As such, acquired angioedema has been associated with B-lymphocyte processes such as lymphoma and monoclonal gammopathies of undetermined significance.

Current treatments for angioedema include antifibrinolytic agents and attenuated androgens for prophylaxis, and plasma-derived C1-INH concentrate for acute attacks. The traditional treatment for splenic marginal zone lymphoma is splenectomy. Given the close link between angioedema and B-cell lymphoproliferative disorders, therapy aimed at targeting the B-cell was undertaken. Rituximab monotherapy resulted in a clinical remission of both angioedema and SMZL.

The successful treatment of this patient with rituximab suggests an exploitable link between the epiphenomenon of autoimmune diseases and B-cell lymphoproliferative disorders. Treatment strategies targeting the B-cell in coincident disorders are successful in treating both conditions, and should be the standard of care for these patients.

Delivery of Cancer Genetic Services: Acceptability of Models of Care in the Geographically Remote Setting

A. Lamb¹, B. Grillo¹, E. McDonald², K. Rasmussen^{1,3}, L. Lucas¹, S. Miesfeldt¹

¹Maine Medical Center, ²MaineHealth, ³Spectrum Medical Group

Background: Advances in genetic/genomic technologies for cancer genetic risk assessment, counseling, and testing are at the forefront of personalized medicine. Questions remain regarding how best to provide guidelines-based cancer genetic services in community settings. Access to these services is especially problematic in rural states. The goal of this work was to assess the acceptability of cancer genetic models of care among Maine residents at risk for hereditary cancer susceptibility disorders.

Methods: A mailed survey to at-risk individuals referred to Maine Medical Center for cancer genetic counseling. Respondents ranked four characteristics of cancer genetic services from most to least important including: provider with formal versus informal genetic counseling training; local versus remote services; in-person versus via telemedicine counseling; individual versus group counseling. Associations between acceptability of models of care and patient characteristics, including rural residence, will be studied.

Results: Forty-seven of 126 (37%) patients responded to date. Respondents were white and represented 11 Maine counties. Almost all patients (46/47) indicated that an important/most important characteristic of a cancer genetic service is the professional qualifications of providers. Sixty-two percent indicated that local access was somewhat/least important. The majority (66%) responded that individual counseling was important/most important. Approximately half (51%) responded that counseling provided in-person was important/most important.

Conclusions: At-risk individuals are willing to travel for cancer genetic services, and are receptive to telemedicine. They view the qualifications of genetic providers and one-on-one counseling as the most important factors. These data are supporting planning and development of cancer genetic services in Maine and may be generalizable to other Northern New England states.

Successful implementation of an extracorporeal photopheresis program for the treatment of cutaneous T-cell lymphoma and chronic graft-versus-host disease

L. Pinheiro, N. Dunbar, Z. Szczepiorkowski, F. Lansigan

Dartmouth-Hitchcock Medical Center

Background: Extracorporeal photopheresis (ECP) is a form of apheresis and photodynamic therapy in which the peripheral blood is treated with 8-methoxypsoralen, which is then activated with ultraviolet light. ECP is currently a standard therapy for cutaneous T-cell lymphoma (CTCL) and is also effective for chronic graft-versus-host disease (GVHD). In May 2008, Dartmouth-Hitchcock Medical Center initiated a regional ECP program.

Methods: UVAR-XTS and CELLEX instruments were used for ECP procedures according to manufacturer and product guidelines.

Results: A total of 734 treatments were planned with 708 procedures successfully completed (96.4% completion rate). Of the 19 ECP patients, 9 patients were treated for CTCL and 10 for GVHD. Patients traveled a median of 53.6 miles (range 4-131.6 miles) from Vermont and New Hampshire. All CTCL patients completed treatment using peripheral venous access while 8 of 10 GVHD patients required catheter placement. The median number of treatments for CTCL and GVHD patients was 17.5 (range 10-52) and 37.5 (8-159), respectively. The median duration of therapy was 6.5 months (range 2-17) for CTCL and 7 months (range 1-25) for GVHD. Responses to treatment will be reported at the time of the meeting.

Conclusions: In summary, ECP is a well-tolerated therapy with no major adverse side effects. ECP can typically be done using peripheral venous access in patients with CTCL, while patients with GVHD usually require apheresis catheter placement. Although distance travelled can be a barrier to treatment, ECP at a regional center should be considered a viable treatment option for CTCL and chronic GVHD.

Treatment of acquired hemophilia A with rituximab: clinical outcomes

M. Roengvoraphoj, E. Jensen, L. Mckernan, A. Briggs, D. Ornstein

Department of Medicine, Dartmouth-Hitchcock Medical Center, Lebanon; Departments of Pathology & Medicine, Dartmouth Medical School, Lebanon, NH

Background: Acquired hemophilia A(AHA) is a rare bleeding disorder caused by autoantibodies to coagulation factor VIII (FVIII). Cyclophosphamide (C) and prednisone (P) have been used as a first-line immunosuppressive treatment for AHA until the late 1990s, when R began to be used off-label for inhibitor eradication. We hypothesized that the use of rituximab (R) is an effective first-line therapy for AHA and can shorten the time to complete remission (CR).

Methods: We performed a retrospective study of patients with AHA, defined by prolonged aPTT (>37 sec), FVIII level <50% and detectable FVIII inhibitor (>0.40 Bethesda Unit (BU)) at Dartmouth-Hitchcock Medical Center (DHMC) using the hospital's electronic medical record system.

Results: We identified 16 patients with AHA treated at DHMC from 1997 to 2010. The median age at diagnosis was 78, and 56% were women. Co-morbidities included malignancy (62%) and autoimmune disease (12%). Idiopathic cases accounted for 32%. R was used in 63% of patients as first-line immunosuppressive treatment. The remaining patients received C and P, P alone or no immunosuppressive treatment. A CR was documented in 63% of patients, of whom 60% received R. The median time to CR for R-treated patients was 28 days and 66 days for non-R-treated patients. Relapses were documented in two patients who achieved CR.

Conclusions: Our findings suggest that R is an effective first-line immunosuppressive treatment for AHA and appears to shorten the time to CR substantially compared to traditional immunosuppression.

Adoptive Cellular Therapy Using Cells Enriched for NKG2D+CD3+CD8+T Cells Following Autologous Transplant for Myeloma

L. Talebian¹, D. Fisher¹, Z. Szczepiorkowski¹, M. Ernstoff¹, C. Sentman², K. Meehan¹
¹ Dartmouth Hitchcock Medical Center, ²Dartmouth College

Background: Despite evidence demonstrating that a higher number of lymphocytes circulating by Day 15 post-transplant predicts survival, the lymphocyte subset responsible is unknown. Based on our preliminary data, we hypothesize that this benefit is due to a subpopulation of CD8+T cells expressing NKG2D, an NK cell activating receptor. NKG2D+CD8+T cells mediate TCR-independent, non-MHC restricted tumor cell killing. Our data indicate that the NKG2D receptor can be up-regulated on CD8+T cells in vivo, rendering them highly effective at killing myeloma cells.

Methods: We developed an ex vivo expansion method that enriches for NKG2D+CD3+CD8+T cells using mobilized blood progenitor cells (Cytotherapy 2008, Cytotherapy 2010). These ex vivo expanded NKG2D+CD8+ T cells aggressively lysed myeloma cells and blocking the NKG2D receptor inhibited this killing. We conducted a phase II trial using adoptive cellular immunotherapy following autologous transplant, using ex vivo expanded cells enriched for NKG2D+CD8+ T cells. Myeloma patients received melphalan followed by an autologous transplant. Low dose IL-2 and GM-CSF were administered post-transplant for 4 weeks. The ex vivo expanded cells were administered at weeks 1, 2, 3, and 8 post-transplant.

Results: Twenty-three patients were accrued. There were no treatment-related deaths and all patients completed their full course of IL-2. Normal platelet and neutrophil engraftment occurred for each patient. There was an increased number and function of NKG2D+CD3+CD8+T cells circulating in vivo at 1 month post-transplant ($p < 0.004$) compared to controls. The circulating NKG2D+CD3+CD8+T cells recognized and lysed autologous myeloma cells ($p < 0.002$). Myeloma cell lysis was inhibited by blocking the NKG2D receptor.

Conclusions: These results suggest that NKG2D+CD3+CD8+T cells recognize and kill autologous myeloma cells in an NKG2D-dependent manner. This lymphocyte subset may improve survival in transplanted myeloma patients. A gene therapy trial is being designed to test this hypothesis.

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