Yale-New Haven Magazine, Fall 2009

Yale-New Haven Hospital

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During the summer, somewhere in Connecticut, a woman was busy with her family, attending cookouts, going to the beach and enjoying life, unaware that she had cancer. Weeks later, she will be stunned by her diagnosis. On Monday, October 26, that woman will walk into the radiation oncology treatment area at the new Smilow Cancer Hospital at Yale-New Haven and be among the first patients treated at the new facility. She will be one of almost 19,000 residents to be diagnosed with cancer in Connecticut this year. But with the opening of Smilow, she will face her diagnosis with new hope instilled by a multidisciplinary team of experts at a state-of-the-art hospital.

More than a terra cotta and glass building, Smilow is an impressive cancer hospital with the most advanced technology. But what goes on inside the walls is what will distinguish Smilow from other hospitals. We have reorganized the care processes so that each patient will have a multidisciplinary team of professionals who specialize in the particular type of cancer he or she has—a brain tumor, breast cancer, endocrine cancer, gastrointestinal cancer, hemato logic cancer, melanoma, childhood cancer, gynecological cancer, head and neck cancer, hematologic cancer, melanoma, childhood cancer, prostate or urologic cancer, sarcoma or lung cancer.

We are able to support 12 outstanding disease-based teams because of our affiliation with Yale Cancer Center, one of only 40 National Cancer Institute-designated comprehensive cancer centers in the country. National Cancer Institute cancer centers are national leaders in cancer research, prevention, detection and treatment. In addition to expert care, Smilow patients will have access to evolving treatment options. Most cancer experts believe that where a patient is first treated for cancer makes a big difference—and choosing Smilow can make a profound difference in the lives of thousands.

Smilow will feel different from other hospitals. The building will transform Yale-New Haven’s existing decentralized cancer services into an organized, efficient, highly coordinated approach to disease-based cancer care. Patients will experience a palpable emphasis on patient- and family-centered care. No diagnosis is more devastating than that of cancer, and the resources we will offer patients and families will make a significant difference in their journey back to health and survival.

The achievement of such an evolution in the way the patient will experience cancer care requires a strong, thoughtful and visionary leader. The recently recruited physician-in-chief of Smilow Cancer Hospital, Dr. Thomas Lynch, Jr., is such a leader, and he is committed to making this work for our patients. In his role as director of Yale Cancer Center, he is also committed to evolving our ability to treat cancers based on scientific advances. Dr. Lynch is impatient with the status quo. “We need to start thinking about curing cancer,” he said, just before he came to New Haven. “We’ve become too content with modest gains, when we need major advances.”

This kind of determination and optimism will help Smilow begin to change some of the cancer statistics for Connecticut, a state in which 7,000 people die from cancer each year.

Since we first announced our plans to build this cancer hospital, the word we have used again and again has been “hope.” Patients use the word frequently. The ironworkers spray-painted the word on the steel beams that hold up the building. On October 26, we will open this building of hope for patients with cancer, and take another giant step forward.

Marna P. Borgstrom, President and CEO

As Smilow Cancer Hospital at Yale-New Haven prepares to open, new leadership is in place, new facilities are close to ready and patients can expect to find 12 multidisciplinary cancer teams offering rapid access to appointments and tests, personal communication and assistance from a patient coordinator and personalized care led by a physician in collaboration with a team of specialists.
I expect Smilow Cancer Hospital at Yale-New Haven will immediately start to change the landscape of clinical cancer care in Connecticut and New England. I would like Smilow to become known for its compassionate patient- and family-centered care, for personalized cancer therapy and for its multidisciplinary team approach to cancer care.

Because cancer is probably the most earth-shattering event to happen to a person, the most important thing we can provide is compassionate care. We will have the finest facility anywhere and the necessary resources to support patients with cancer and their families.

When I was chief of hematology/oncology at Massachusetts General Hospital Cancer Center, I helped establish multidisciplinary care as a standard. Smilow Cancer Hospital is organized around a multidisciplinary team approach to patient care—12 “disease programs” to care for patients with various types of cancer. Each of these cancer programs is affiliated with Yale Cancer Center. All the specialists and support staff are brought together in a team to develop an individualized medical approach for every patient.

Smilow is an ideal size to support teams of practicing physicians collaborating with researchers and to develop “personalized medicine” that will improve the treatment plan based on the individual patient’s specific characteristics, including age, gender, height, weight, diet, environment and family history, as well as the patient’s specific tumor type. Personalized care—which is currently in use at Yale-New Haven and will continue to expand—is essentially getting the right drug to the right patient. This means targeting the therapy to the genetic abnormality in the patient’s tumor and designing the treatment specifically for that patient and the underlying characteristics of that patient’s tumor.

With Smilow opening, we will begin to become nationally known for our expertise in personalized cancer therapy, using molecular profiling to match therapy to the genetic signature of the patient’s tumor, as well as a commitment to quality, safety and outcomes measurement.

Patients in Connecticut are fortunate to live near a nationally designated cancer center. Yale Cancer Center is southern New England’s only comprehensive cancer center designated by the National Cancer Institute (NCI). It is one of only 40 in the nation. When the NCI created the first eight comprehensive cancer centers in 1971, Yale’s was among them. It is a collaborative venture between Yale School of Medicine and Yale-New Haven Hospital, a partnership that enables the Center to provide the newest advances and best approaches for the detection, diagnosis and treatment of the disease.
Cancer Hospital. Smilow will be an absolutely fabulous facility. I’m a big believer in cutting-edge research and in quality, safety and outcomes measurement — but the pursuit of clinical excellence is the most important component of any cancer center.

We have organized most of our cancer care into 12 cancer programs. These programs are all based on a multidisciplinary team approach. Key characteristics of our programs are:

- Patient-centered care
- Rapid access to appointments and relevant tests
- Personalized care led by a physician in collaboration with a team of specialists
- Personal communication and assistance from a patient coordinator
- Compassion and support for the psychological aspects of cancer care
- Rapid communication with and involvement of outside primary care and referring physicians

I came here specifically because of Yale’s West Campus and Smilow Cancer Hospital. Smilow will be an absolutely fabulous facility. I’m a big believer in cutting-edge research and in quality, safety and outcomes measurement — but the pursuit of clinical excellence is the most important component of any cancer center.

The Brain Tumor Program offers advanced treatment for patients with primary brain tumors, brain metastases and neurological complications of cancer. As part of the only interdisciplinary consortium providing comprehensive brain cancer care in southern New England, the coordinated team of medical professionals — including recognized leaders in the fields of neurosurgery, neurology, medical oncology, neuro-oncology, therapeutic radiology, neuropathology and neuroradiology — focuses exclusively on understanding and treating brain cancer.

At Smilow Cancer Hospital, brain tumor specialists will have access to the most advanced surgical tools and robot-assisted machines, including intra-operative magnetic resonance imaging (MRI) and functional MRI for language and critical motor and language skills mapping.

The Brain Tumor Program offers a wide spectrum of tools to diagnose and treat brain cancer, making it possible to make precise diagnoses and develop more effective interventions for tumors of the brain. Patients benefit from specialized resources such as a dedicated neurological intensive care unit and the latest imaging technologies.

A full range of traditional and innovative treatments is available, including surgery, radiation therapy, stereotactic radiosurgery, chemotherapy and novel experimental therapies.

The Brain Tumor Program has gained regional and national recognition for continually pushing science and technology toward a cure. Clinical trials for newly diagnosed and relapsed glioblastoma multiforme (GBM) — the most common and most aggressive type of primary brain tumor — are based on tumor-directed vaccines and angiogenic drugs that stop new vessels from forming around a tumor and break up the existing network of abnormal capillaries that feeds the cancerous mass.

Patient referrals and supply physicians with regular reports on diagnostic findings and treatment recommendations. Patients can be referred for the development of a treatment plan in conjunction with their primary physician, for a second opinion, or for ongoing management by the Brain Tumor Program physicians.

Symptoms of Brain Tumors
- Persistent headache
- Nausea and vomiting
- Seizures
- Speech problems, impaired vision, weakness in parts of the body, trouble walking and general confusion

Symptoms of Spinal Cord Tumors
- Pain or numbness below a certain level on the body
- Weakness in both legs or all four limbs
- Difficulty controlling bowel and/or bladder function

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As director of the MSK Thoracic Oncology Center, Dr. Lynch made important contributions in developmental therapeutics and in defining the optimal treatment for patients with lung cancer.

Dr. Lynch also will oversee a new institute for cancer biology at Yale’s 136-acre West Campus, for which he will be recruiting scientists in the fields of cell signaling, cancer immunology and drug development and target acquisition.

Thomas J. Lynch, Jr., MD, a graduate of Yale University and Yale School of Medicine, returned to New Haven this April from Boston, where he was the director of the Center for Thoracic Cancers at Massachusetts General Hospital (MGH) Cancer Center and director of medical oncology at the MGH Thoracic Oncology Center, as well as professor of medicine at Harvard Medical School.

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Symptoms of Breast Cancer

- Breast lump or mass
- Discharge from nipples
- Swelling, skin irritation or dimpling
- Breast or nipple pain, thickening of the nipple or breast skin
- A lump in the underarm area
- Pain or abnormalities on mammograms

Breast Cancer Program

The Breast Cancer Program provides multidisciplinary, patient-focused care to women diagnosed with breast cancer. Breast cancer — the most common cancer in women — is the presence of a malignant tumor that forms from cells of the breast; it most frequently begins in the cells that line the ducts. A woman's breast is made up of glands, ducts, tissues, blood vessels and lymph vessels. The earlier breast cancer is detected, the better the chances that treatment will be effective, so the goal is to find cancers before they begin to cause symptoms.

Treatments for breast cancer include surgical procedures such as lumpectomy, mastectomy and breast reconstruction, as well as biopsies, ultrasound and advanced oncoplastic procedures. Most breast cancer patients also need chemotherapy or hormonal therapy, in addition to surgery and radiation. Patients in the Breast Cancer Program also have access to state-of-the-art clinical trials of novel therapeutics and radiation therapy.

The program's health professionals provide coordinated, simultaneous appointments, rapid diagnosis and treatment and access to the most up-to-date technology and research protocols. Additionally, surgeons affiliated with the Breast Cancer Program perform breast surgery exclusively, making them more likely to understand the complexities of breast cancer diagnosis and treatment.

Patient support staff provide essential services such as social work, pastoral support, nutritional advice, physical therapy and rehabilitation. Most important, patients receive personal, friendly, confidential care designed to meet the needs of the whole patient, not just the disease.

Hormone replacement therapy
- Elevated estrogen levels
- Early menopause (before age 12) or late menopause (after age 55)
- Never having been pregnant or having first baby after age 30
- Exposure to radiation
- A mother, grandmother or sister who has had breast cancer

Breast Cancer Risk Factors

"The Breast Cancer Program pays careful attention to achieving the highest chance for cure, with the best possible cosmetic results and quality of life. Addressing the psychosocial needs of breast cancer patients is also an integral part of diagnosis, treatment, research and follow-up in the Breast Cancer Program."

By Myra Stanley

Bridgette DeLacey, chief technologist, in the Yale-New Haven Breast Center, prepares a patient for a mammogram. The Yale-New Haven Breast Center is moving from Yale Physicians Building to Smilow.
"Thyroid surgery, though generally not life-threatening, can be associated with complications, including injury to the vocal cords or parathyroid glands, which control calcium metabolism. Research confirms that the most important factor for both avoiding complications and enhancing favorable clinical outcomes from the treatment of thyroid disease is the experience of the surgeon."

The Endocrine Cancers Program offers evaluation, diagnosis and treatment of tumors of the thyroid, parathyroid, adrenal glands, pituitary gland, hypothalamus and pancreas. Thyroid cancer is the most common endocrine malignancy. Yale-New Haven has one of the largest multidisciplinary endocrine cancer teams in the United States - including surgeons, endocrinologists, medical oncologists, pathologists, radiation oncologists and cytopathologists - who handle about 1,000 cases a year.

Thyroid cancer begins as a tumor that develops in the thyroid, a butterfly-shaped gland at the base of the throat. The thyroid produces hormones that help the body work normally. Although many thyroid tumors are benign and thus not cancerous, there is a tremendous advantage to being evaluated and treated by experts in endocrine diseases.

**Symptoms**

- A noticeable lump in the neck
- Trouble breathing
- Trouble swallowing
- Pain in the neck or vocal cord dysfunction, often with hoarseness

**Risk Factors**

- Being between 25 and 65 years old
- Being female
- Being Asian
- Exposure in childhood to radiation to the head and neck
- History of goiter (enlarged thyroid)
- Family history of thyroid disease or thyroid cancer
- Certain genetic conditions, such as familial medullary thyroid cancer (FMTC), multiple endocrine neoplasia type 2A syndrome, and multiple endocrine neoplasia type 2B syndrome

**Diagnosis and/or Early Detection**

- History and physical exam
- Fine-needle aspiration biopsy
- Laryngoscopy
- Blood studies
- Ultrasound
- CT scan
- PET scan
- MRI
- Surgical biopsy

**Treatment Options**

Depending on the patient's age and general health, and the type and stage of the thyroid cancer, the four standard treatment options are surgery, radiation therapy (including radioactive iodine therapy), thyroid hormone therapy and chemotherapy.
Symptoms

Although other conditions may cause the same symptoms, you should consult a doctor with any of the following:

- Azites (build-up of fluid in the abdomen)
- Bloating
- Blood in the stool
- Fever
- Heartburn
- Indigestion and stomach discomfort
- Itchy skin
- Jaundice (yellowing of the skin and whites of the eyes)
- Loss of appetite
- Lumps in the abdomen
- Nausea and vomiting
- Pain or cramps in the middle of the abdomen
- Trouble swallowing
- Unexplained weight loss

Risk Factors

Age, diet and health history can affect the risk of developing gastrointestinal cancers.

Treatment Options

The program offers nationally accepted treatment plans for patients who have recently been diagnosed with cancer, and carefully customized plans for patients who have not responded to prior therapies, as well as clinical trials for both groups of patients, when appropriate.

- Surgery
- Transtrabecular chemodenervation (TACE)
- Liver transplantation
- Chemotherapy
- Radiation therapy

Gastrointestinal Cancers Program

“Smilow Cancer Hospital at Yale-New Haven works in partnership with the nationally recognized Yale Cancer Center and benefits from its groundbreaking research and world-class physicians. Our physicians have special expertise in the treatment of cancers of the pancreas, colon and rectum.”

With each year, nearly 200,000 people in the United States are diagnosed with some form of gastrointestinal cancer. Many of these cancers are too complex or difficult to treat with just one modality. The Gastrointestinal Cancers Program provides all gastrointestinal cancer patients with a truly multidisciplinary approach to the treatment of their complex disease.

Patients are seen in an individualized manner by several cancer specialists—medical oncologists, radiation oncologists, gastroenterologists and a surgeon—on their initial visit to Smilow Cancer Hospital. These physicians work together to develop a comprehensive treatment plan that is clear and concise. In one visit, patients encounter a team of physicians who work together, combining their skills and knowledge to provide the highest quality of care.

Physicians in the Gastrointestinal Cancers Program care for patients with gastrointestinal, liver, gastrointestinal, colon and rectal cancers. Using a team approach, our physicians collaborate with diagnostic and interventional radiologists, gastroenterologists, hepatologists and pathologists to provide the most advanced care available. Our diagnostic imaging services include: endoscopic retrograde cholangiopancreatography (ERCP), magnetic resonance cholangiopancreatography (MRCP), and high-resolution computed tomography (CT) scans, endoscopic ultrasound (EUS) and EUS-guided fine-needle aspiration.

Gynecologic Cancers Program

“Our multidisciplinary approach means that our patients benefit from the best medical minds coming together to determine the optimum course of treatment for gynecologic cancers. Supported by a team of medical oncologists, radiation oncologists, surgeons, oncology nurses and researchers, our patients can face their disease from a position of strength.”

With gynecologic cancer is unique, with different signs and symptoms, different risk factors and different prevention strategies. All women are at risk for gynecologic cancers, and risk increases with age. A woman who is experiencing abnormal or pelvic pain should see her doctor. Symptoms may be caused by something other than cancer, but an evaluation by a physician is the only way to know for sure.

At Smilow Cancer Hospital, gynecologic oncology services unite a multidisciplinary team of clinicians. Our physicians are board-certified in obstetrics and gynecology and in the subspecialty of gynecologic oncology, which brings together surgery, chemotherapy and radiation therapy.

Conditions we treat:

- Precancerous changes of the vulva, vagina and cervix, including dysplasia and carcinoma in situ
- Premalignant changes of the endometrium, including adenomatous hyperplasia
- Vaginal cancer
- Vaginal cancer
- Cervical cancer
- Urinary cancer
- Fallopian tube cancer
- Ovarian cancer and gestational trophoblastic disease
- Gynecologic fibroids

Diagnosis:

We have a full-service colposcopy program to help diagnose premalignant and malignant reproductive diseases, and we offer laser, loop electrical excision procedure (LEEP), and cold-knife conizations for cervical cancer and, in selected patients, for vaginal and vulvar cancer.

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Head and Neck Cancers Program

"We always urge people who may have tell-tale symptoms to get checked. Although the number of people who develop head and neck cancers is not huge, these diseases are often devastating because they affect one’s ability to smile, speak and eat. Speech makes us unique as humans, and our faces are the signature of our individuality. A preventive screening or annual check-up by a specially trained ear, nose and throat (ENT) physician is the best prevention."

The Head and Neck Cancers Program includes an experienced, multidisciplinary team that offers broad-based specialized care in early detection, treatment and prevention of various head and neck diseases, including those of the lip, mouth, nasal cavity, sinuses, larynx, pharynx, ear and skull base. In addition to surgeons, nurses and clinicians, the team includes skilled rehabilitation specialists in the areas of speech, swallowing and hearing restoration.

Head and neck cancers are frequently aggressive and may also spread to the lymph nodes of the neck. Patients often develop a second primary tumor. If detected early, head and neck cancer is highly curable, usually with some form of surgery, although chemotherapy and radiation therapy may also play an important role. An exciting new surgical technique allows surgeons to remove tumors without an open incision in the neck.

Reconstructive surgery has improved dramatically, yielding previously unattainable cosmetic and functional outcomes.

Symptoms
- A persistent sore throat (more than six weeks)
- Difficulty swallowing or a lump in the neck
- Hoarseness or a change in voice
- Indigestion, heartburn or weight loss
- Signs of blood in saliva
- Pain behind the breastbone
- Ear pain

Risk Factors
- Tobacco smoking
- Alcohol consumption
- Ultraviolet light
- Occupational exposures

We are now moving toward a more personalized form of cancer care. We appreciate the understanding of the biology of each patient’s disease and the collection of several distinct types of cancers, and each patient is different. Improved treatment outcomes are increasing survival rates, leading to better treatments and curing up to 80 percent of patients with Hodgkin’s lymphoma. Dramatic advances have also been made in therapy for certain forms of leukemia, for example, with the development of molecularly targeted therapies such as Gleevec® for a leukemia termed chronic myeloid leukemia (CML). The outlook for patients with myeloma, another blood cancer, has also significantly improved over the last decade, with the introduction of new therapies such as thalidomide and bortezomib.

Several Smilow physicians are also experts in stem cell transplantation, which is part of standard therapy for selected patients with leukemia, lymphoma or myeloma. For example, Yale-New Haven is one of a handful of cancer hospitals in the country to perform haploidentical transplants, which allow patients to be transplanted with mismatched or half-matched donor stem cells from a family member with whom they have only one set of genes in common. There are no routine screenings for blood cancers, and symptoms are often similar to those of less serious conditions. But Smilow physicians urge anyone who is feeling a loss of well-being or persistent low-grade fever, unexplained weight loss, tiredness or shortness of breath to talk to their doctor about it.
“At this time, standard treatments for advanced melanoma are effective in only a small percentage of patients. Nationally designated cancer centers such as Yale Cancer Center offer investigational treatments for metastatic melanoma and maintain laboratory research programs to discover new ways to treat the disease.”

The Melanoma Program brings together experts from diverse fields to provide patients with new and state-of-the-art treatments. The multidisciplinary team, which includes surgeons, medical oncologists, dermatologists, radiologists and surgical and dermatologic pathologists, draws on its experience in the diagnosis, treatment and care of patients.

Melanoma is a disease in which malignant cells form in the skin cells called melanocytes (cells that color the skin). It can occur anywhere on the body. It is more aggressive than the other two types of skin cancer, basal cell and squamous cell skin cancer.

Dermatologists generally provide the initial care of patients by examining the skin and removing any unusual-looking mole or skin lesion (abnormal tissue). If a biopsy of the suspicious tissue confirms a diagnosis of melanoma, the patient is referred to a surgeon or medical oncologist for a more extensive excision of the melanoma lesion. Depending on the appearance and depth of the melanoma, additional diagnostic studies can help determine if the melanoma cells have spread to other internal organs.

Many melanomas can be cured by surgery alone. If the lymph nodes contain melanoma cells, the rest of the lymph nodes in the same area are removed by the surgeon. However, sometimes even at the time the melanoma is first diagnosed, it may already have spread to other parts of the body. Over time, tumors may grow in the lungs, the liver or other organs. Spread of the melanoma to other parts of the body (called metastatic disease), if untreated, can lead to death over a period of months to years.

In addition to surgery, standard treatment can include chemotherapy and biologic therapy. Currently, there are multiple clinical trials available for patients with metastatic melanoma. The Melanoma Program has one of only four NIH-funded Specialized Programs of Research Excellence (SPORE) grants in the country; these grants support research projects in melanoma. Also, the Milstein Meyer Center for Melanoma Research and Treatment is dedicated to developing more investigator-initiated clinical trials and designing new treatments for the often fatal illness.

### Symptoms

- A mole that:
  - changes in size, shape or color
  - has irregular borders
  - is more than one color
  - is asymmetrical
  - itches
  - oozes, bleeds or is ulcerated
- Changes in pigmented skin
- New moles that grow near an existing mole

### Risk Factors

- Unusual moles
- Exposure to sunlight or artificial sources of ultraviolet light, including tanning salons
- Family or personal history of melanoma
- Caucasians are more susceptible, as are those who are over 20 years old, have light skin, freckles or blue eyes
Pediatric Oncology Program

"Our mission is to offer the best medical care in the most optimal environment for pediatric patients and their families. We are spreading the Smilow umbrella of cancer care to encompass all of Connecticut and beyond."

The Pediatric Oncology Program offers the latest advances in diagnosing and treating childhood cancer and blood disorders. The Pediatric Oncology Program is supported by a multidisciplinary clinical team of physicians and highly skilled advanced practice nurses with expertise in all aspects of care for children with cancer.

The team meets every week to develop individualized treatment plans for each patient and discuss new and current cases. A pediatric oncologist coordinates the multidisciplinary care, which can involve many services, such as pediatric diagnostic imaging, radiation oncology, laboratory medicine, pediatric surgery, pediatric neurosurgery, orthopedics, pediatric pathology and neuropathology. Yale-New Haven also is in the planning stage of instituting the only pediatric bone marrow/stem cell transplant program in Connecticut.

The Pediatric Oncology Program treats 80-100 new cancer patients a year, and also provides care for complex and challenging benign tumors, as well as sickle cell disease, hemophilia, coagulation abnormalities and platelet disorders. While most pediatric cancer care is delivered on an outpatient basis, when a child's acute medical needs require hospitalization, pediatric patients are admitted to Yale-New Haven Children's Hospital — which is attached to the newly built Smilow Cancer Hospital on the seventh floor by a walking bridge. The seventh floor of Smilow is devoted to pediatric oncology patients, with more than 5,000 square feet of space that includes four exam rooms, two negative- and two positive-pressure isolation rooms to help keep immunosuppressed or contaminated patients healthy, a family lounge area, two consultation rooms and a dedicated infusion room.

In addition to the oncology expertise provided by the pediatric hematologist and oncology team, many supportive care services are available, such as social work and child life, clown visitation, and music and massage therapists, to help both children and families to cope with illness and treatment.

Chilhood cancer patients at Yale-New Haven Children's Hospital are regularly offered enrollment in clinical trials through the Children's Oncology Group (COG), an organization dedicated to curing childhood cancer by providing national and international clinical trials.

Smilow Cancer Hospital 16
Sarcoma Program

"In our practice, we see uncommon things—commonly. We have the team to identify why individuals are ill and provide the most effective way to make them better. Experience happens in other places, too. But in our geography, this has been, is and will be the best place for care."

By Leah Colihan

Gary E. Friedlander, MD
Disease Team Leader

Sarcomas, which generally account for about 1 percent of cancers, fall into two main categories: bone and soft tissue. When a "cellular misadventure"—that is, cancer—is suspected, the sarcoma team assesses the best course of action. Research that has been done at Yale Cancer Center, in the United States, has dramatically improved the treatment for sarcoma. Forty years ago, for example, patients might have first received surgery to remove a tumor—usually by amputation, possibly followed by a course of chemotherapy or radiation. The survival rate in those days was about 10-15 percent for two years. Clinical research trials show that today's patient will probably benefit from a course of multi-drug chemotherapy and/or radiation first, followed by limb-sparing surgery, which removes the tumor without amputation, and more chemotherapy. In rare cases, amputation is the best approach, but again, a team well-versed in a range of options can knowledgeably share the decision-making with the patient. Today, the cure rate—not the survival rate—for sarcoma is around 80 percent.

Lung cancer is still a frightening form of cancer, but patients who visit Smilow Cancer Hospital find their options for a good outcome are changing rapidly. Many patients with advanced stage disease are surviving for years with new cutting-edge treatments, and physicians are looking toward a future where they can talk about the once-fatal disease as a chronic illness. Smilow's Thoracic Oncology Program is a leader in treatment of lung cancer and other thoracic malignancies, such as esophageal cancer, thymoma and chest wall tumors.

As soon as a new thoracic oncology patient's CT scans, biopsies and other test results are available, Smilow physicians see the patient, review the evidence, discuss the case at the weekly multidisciplinary thoracic tumor board and decide on the best course of treatment based on the collective judgment of the team. Three factors are raising the bar on outcomes for patients at Smilow. The first is the collaborative team approach, in which the patient's physician draws upon the collective expertise of the national and international experts at Yale-New Haven. The second is a focus on evidence-based practice in which physicians employ the latest standards of treatment. The third factor comes from continually pushing the forefront through clinical research that is defining better therapy.

By Kathy Kirsch

Thoracic Oncology Program

"We have diagnosed many people with stage IV lung cancer, and several years later, they’re doing just fine. We never saw that 10 years ago. We still have a lot of work to do before we can consistently talk about lung cancer as a chronic disease, but this type of cancer is a whole different ballgame than it used to be."

Symptoms

- A cough that does not go away or gets worse over time
- Coughing up blood
- Unexplained chest pain
- Shortness of breath
- Wheezing
- Persistent hoarseness

Treatment

Treatments may combine techniques and technologies, such as external beam radiation therapy, minimally invasive video-assisted surgery for lung and esophageal cancers, and many active "third-generation" and "targeted" chemotherapy agents. Treatment advances have occurred in each area—the majority of surgeries for thoracic cancers are done by minimally invasive techniques, something available at only a minority of institutions nationally. Technology advances in radiotherapy such as 4-dimensional treatment planning are standard at Yale-New Haven, but are not yet available at many academic centers. Finally, the development of newer chemotherapy agents that are more active with fewer side effects are allowing even stage IV cancer patients to offer live for years.

While there are still no generally accepted early detection screenings for these cancers, physicians encourage people to drop their fear of esophageal and lung cancers and talk to their doctors about unusual signs or symptoms. Although smoking is not the only risk factor for thoracic cancer, anyone who smokes should seek help if they need it to quit smoking.
Smillow Cancer Hospital at Yale-New Haven is expected to become the most comprehensive cancer care facility in New England. The building consolidates Yale-New Haven's inpatient and outpatient cancer services, with a specialized women's cancer center, as well as a floor for diagnostic and therapeutic radiology.

Yale-New Haven Hospital treats more cancer patients than any other hospital in the state. YNHH care givers use a multidisciplinary approach to help patients and families through diagnosis and treatment. Physicians meet to discuss every patient's care, diagnosis and treatment options, so they can develop a unique, comprehensive treatment plan for each patient that can include surgery, chemotherapy, radiation or a combination of treatments. YNHH offers counseling, treatment, psychosocial support, pain management, rehabilitation and long-term, follow-up care. In addition, Yale-New Haven patients often have the opportunity to take advantage of clinical trials that are not available at most hospitals.

As a baker, Caroline Giori was so precise that a pastry chef friend called her the next best thing to a machine. She shaped her butterballs and whiskey balls by eye, so exact you could have measured them with a ruler and found each one to be the same. So it came as a surprise when her husband, Cesare, noticed the first signs that she was getting confused about things. While writing checks to pay the bills, Caroline was copying the amounts from old canceled checks because she was having trouble writing numbers. It was Alzheimers, and it gradually progressed to the point where she stopped talking. She would go into the shower only to use all the towels to wipe down the shower wall. She would sleep only if Cesare drove her down the Merritt Parkway from Woodbridge to New York and back.

"It's a heartbreaking illness that reverses your cycle of life," said Cesare, who was determined to care for his wife at home. "It takes them from an adult and brings them back to a baby. You have to give them all the love you can."

Giori brought Caroline to the Dorothy Adler Geriatric Assessment Center at Yale-New Haven Hospital for an evaluation, and continued bringing her for follow-ups for the next 11 years. The doctors were clear that there is no cure for Alzheimers and there are limits to treatment, but Giori feels just getting support, including medications to relax her and prevent seizures, advice on what to expect and someone to answer his phone calls even on weekends, may have helped beat the odds a little. Six years ago Caroline Giori was given six months to live. She passed away in 2019 at the age of 74, 20 years after she was given six months to live. She passed away in 2019 at the age of 74, 20 years after she was given six months to live.

Dorothy Adler Geriatric Assessment Center
A place to turn with aging and Alzheimers
by Kathy Katella
A group of clinicians and social workers established the Adler Center in 1981 in Yale-New Haven Hospital's Primary Care Center, to provide better care for older individuals who were showing up in the emergency room. In 1987, it expanded into a fully staffed center and moved into YNHH's Tompkins Basement. It was named for a patient named Dorothy Adler, whose family provided financial support.

Last fall, the Adler Center moved into new offices in a free-standing building at 874 Howard Avenue in New Haven, with convenient parking, updated exam rooms and dedicated family conference rooms. It is now one of the oldest and busiest centers for comprehensive geriatric assessment in the country. Its 12 geriatricians and psychiatrists, and three master's-prepared registered nurses who serve as case managers, saw more than 2,400 patient visits last year, from throughout Connecticut and beyond.

In 20 years, Adler caregivers have seen significant changes in their case load. "The fastest-growing segment of the population in this country are those who are 85 and older," said Leo Cooney, MD, section chief of geriatrics at YNHH and Humana Foundation Professor of Geriatric Medicine at Yale School of Medicine. Dr. Cooney's career has focused on helping elderly individuals attain the highest level of independence possible since he arrived at Yale in 1976.

"In 1970, there were less than 5,000 people aged 100 and older. Now there are 100,000. There is a huge increase in the oldest old. Many of these elderly people have a lot of difficulty caring for themselves. Only about 25 percent of them are fully independent in all of their activities."

Common problems doctors see at the Center are loss of self-care skills, loss of mobility, difficulty walking, falls, confusion, memory loss, agitation, depression, complex medical problems and long-term care issues. Cognitive impairment occurs more commonly with advancing age, whether it is a worrisome phase of forgetfulness, a decrease in cognitive function after a cardiac problem, or Alzheimer's disease, which is frequently seen in individuals in their 40s and 50s with Down syndrome.

During her evaluation, Hortense Haff spent time with geriatric psychiatry fellow Centro Paulo, MD (center photo), and Raje Sh Tampi, MD (bottom and left photos). Hortense's daughter Anne-Marie Brungard Knight spoke with case manager Sigrid Wiemers, MSN (top photo).

"Families need direction with all of this," said Richard Marottoli, MD, medical director of the Adler clinic and associate professor at Yale School of Medicine. "We take a unified approach to addressing not only the patient's issues, but also the family's issues."

When a new patient arrives at the Adler Center for his or her 90-minute initial appointment, one of the case managers meets with the family in one of the Center's dedicated family rooms to collect medical history, talk about current problems with memory, mood and function, and discuss community resource options to meet care needs.

"We've got a laundry list of things we can do," said Diane Davis, RN, MSN, a case manager at Adler for 20 years. She has helped families get started on a living will, arrange a power of attorney, address safety issues, connect with community resources such as adult day care programs, and discuss assisted-living facilities. "The number-one thing we do is try to get family members to work together to provide care. Number two is to tell them not to be angry with the person who is demented, because they can't help it, and number three is to provide them with tools and resources that can help everyone function as well as they can."

Meanwhile, a physician examines the patient. Adler Center physicians have various interests and specialties, which range from chronic lung disease to rheumatology to sleep medicine and psychiatry. They often prescribe the medications available to help slow cognitive decline.

Depression is also common in elderly patients, and doctors do see significant improvement when they prescribe antidepressants and other medications to manage psychiatric disorders, sleep problems, anxiety and agitation.

"Elderly people may get depressed because they are upset about changes in their health and functional status," Dr. Marottoli said. "They may be coping with the loss of a spouse, children, friends or social connections that have disappeared over time. They may be socially isolated. It can be difficult to distinguish depression and mood problems from cognitive problems, because they can look very similar, especially in the early stages."
Diana Adler, 96, of Trumbull brought her husband, Leo, a Harvard Law School graduate, to the Adler Center in 1993. Leo was experiencing an unusual physical condition that other doctors hadn’t been able to identify. It was a terrible situation, and Diana was running out of places to turn. Finally, a physician in New York, who was a friend of their son’s, told the Alchos that the Adler Center was the only place to go.

Claudia Bemis, MD, working with Dianne Davis, treated Leo with medication for a chemical imbalance, and it brought him back to normalcy. The couple kept in touch with Bemis and Davis. Several years after the initial diagnosis, Leo came to the Center for help with dementia and agitation. He was afraid to go to sleep, saturated about things he experienced in World War II, and paced restlessly through the night.

“On the staff at the Adler Center understood him,” Diana Adler said. “I can’t even begin to tell you how much I appreciated them. Dr. Bemis and Dianne Davis were just wonderful. It was not only their professional capacity. It was also their kindness, and their ability not only to cope with my husband, but also to reassure me.” Leo passed away three years ago at the age of 96, and Davis attended a memorial in his honor. Diana has visited the clinic for help coping with her grief.

Remote Patrol: TeleStroke uses videoconferencing technology to link Yale-New Haven neurologists with stroke patients

By Bob Woods

On January 13, Eunice Smith was sitting quietly in the living room of her home in Quaker Hills, just north of New London. At about 1:30 on a chilly afternoon, Eunice, two days shy of her 72nd birthday, was crocheting while her husband Calvin dozed in his favorite easy chair. Suddenly, I coughed,” she remembered. “A moment later, I couldn’t speak, and my whole right side went numb. I was aware, but kind of not with it.”

Her cough startled Calvin awake. “It didn’t sound right,” he recalled. He looked over at Eunice who sat motionless and immediately sensed something was wrong. “I called 911 and said, ‘I think my wife is having a stroke.”

The paramedics arrived within minutes to find Eunice unresponsive. They rushed her to the emergency department (ED) at Lawrence & Memorial Hospital in New London, one of Connecticut’s Primary Stroke Centers. Waiting and ready to take action, the ED’s stroke team quickly evaluated Eunice to determine whether she was experiencing an ischemic stroke. If so, the ED team can administer a “clot-busting” drug known as tPA (tissue plasminogen activator) to dissolve the offending clot, tPA can greatly reduce the risk of lasting neurological deficits.

Nearly 50 miles away, at Yale-New Haven Hospital, Karin Nystrom, APRN, was on the other end of the line. Coordinator of YNHH’s Primary Stroke Center, she also oversees the administrative needs of the hospital’s TeleStroke program, a high-tech videoconferencing and image-sharing service launched in June 2009. The program offers 24-hour remote acute stroke care by YNHH neurologists to outlying hospitals—in Eunice Smith’s case, Lawrence & Memorial. In TeleStroke parlance, YNHH is the “hub” and L&M is the “spoke.”

Less than 10 minutes after Nystrom received the call, L&M’s ED stroke team was connected—over a dedicated Internet link supplying real-time video, audio and data—to YNHH’s Haakon Nygaard, MD, one of four “tele-neurologists” who provides consultation. The technology enables the hub and spoke teams, each equipped with web cameras and color monitors, to see and speak live with each other and to share digitized CT brain scans and data.

The critical, time-sensitive nature of the hub-spoke collaboration is to assess whether the patient is having an ischemic stroke. If so, the ED team can administer a “clot-busting” drug known as tPA to dissolve the clot, restoring blood flow and oxygen to the brain. A breakthrough medication approved by the Food and Drug Administration in 1996, tPA must be given to a stroke victim within four-and-a-half hours of the onset of symptoms. Aside from rapidly dissolving the offending clot, tPA can greatly reduce the risk of lasting neurological deficits.
From his workstation, Dr. Nygaard remotely controlled the web cam on the TeleStroke cart at L&M to visually confirm that Eunice was presenting with any of the classic signs of stroke: facial droop, trouble speaking and weakness on the right side. He spoke with emergency medicine physician Craig Bryant, MD, and nurses Cheryl Cone, RN, and Angela Lamoureux, RN, as well as Eunice’s husband Calvin, to review the chain of events and obtain a cursory medical history of Eunice.

Before long, L&M had taken and uploaded a CT scan of her brain, which Dr. Nygaard examined on his monitor, along with other test results entered in the TeleStroke database. The scan verified that she had not suffered a less-common intracerebral hemorrhagic stroke, which is caused by a sudden rupture of an artery in the brain and results in bleeding, thereby negating the need for a clot-buster. Ultimately, Dr. Nygaard, with the consensus of the L&M team, concurred that Eunice was likely experiencing an ischemic stroke and would be an ideal candidate for tPA.

An hour and 20 minutes after Eunice arrived at L&M, an intravenous line was delivering tPA. Ninety minutes later she started moving the fingers on her right hand, then held up her right arm. Within two hours she was able to speak again. “I’m fine,” were her first words, followed by cheers from everyone in the ED. By mid-June, just after Eunice and Calvin returned from a well-deserved vacation in Barbados, the only ill effect she reported was a slight limp in her right leg. Eunice’s upbeat news happened to coincide with the one-year anniversary of YNH’s TeleStroke Program.

Telemedicine first took hold when the interactive telecommunications technology of the 1960s converged with the growing need to supply specialty medical care to people in rural and remote locations. Using telemedicine to care for stroke patients first developed in the mid-1990s, spurred by the emergence of tPA, as well as advances in computer, teleconferencing and broadband Internet technology. At the same time, “there existed a paucity of neurologists who specialized in acute stroke and at the same time there was a need to deliver acute stroke care to rural areas and inner-city hospitals with few resources to support such a service,” said Nystrom. “So the idea of TeleStroke made sense because you could deliver care to a remote area as long as they had the infrastructure necessary to assess patients for acute stroke symptoms and to administer tPA.”

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An expert neurologic assessment for patients with acute stroke systems is essential. Not only do other disease presentations mimic a stroke, such as hypoglycemia, but both hub and spoke teams must ensure that the patient meets all the necessary criteria for tPA.

"The diagnosis of an ischemic stroke during the first few hours is typically a clinical diagnosis," said Joseph Schindler, MD, clinical director of the YNHH Stroke Center and its TeleStroke program. "That's why it's important to have a neurologist involved in order to properly evaluate these patients."

YNHH's TeleStroke program is the first in Connecticut, and L&M is its first 'spoke' facility. "It was a natural progression for us to offer our expertise regionally, because we have academic neurologists who are on the cutting edge," Nystrom said.

The TeleStroke system includes computer-based videoconferencing set-ups in the stroke center, the intensive care unit and in each of the four neurologists' homes. "We're all on a rotation, 24/7, and are committed to a 10-minute TeleStroke video response time with L&M," Dr. Schindler explained.

The partnership with L&M is ideal for several reasons. L&M had an established infrastructure for delivering stroke care; however, its staff of neurologists was dwindling. "When I first started here, about two years ago, we had five neurologists," said Lisa Bedard, APRN, coordinator of the Stroke Center and TeleStroke at L&M. "Right now we have two neurologists supervising the care of stroke patients at our hospital, and these resources would not support a 24/7 service. The hospital did not want to lose its Primary Stroke Center status, so TeleStroke was the perfect solution."

Above and beyond the hardware and software on both ends of the network, there were people issues to address, too. "The key was getting buy-in from the ED doctors," Dr. Schindler observed. "By its very nature, TeleStroke creates a situation where outside neurologists on a TV screen are directing and consulting on care of their patients. This exemplifies true collaboration in which ED physicians and (remote) neurologists trust each other."

"There's a practice culture within every institution," Dr. Schindler continued. "Our goal was never to disturb that culture. We wanted to enhance their level of stroke expertise while helping them create and maintain their own, independent way of taking care of people."

It didn't take long for the respective doctors, as well as the other support staff at both hospitals, to develop a mutual rapport. "It was an exciting process to be involved with," Nystrom said of the situation at L&M. "Because nurses developed a keen interest in caring for these patients, and ED docs became an integral part of the evaluation from the beginning. The consecutive successes we've had around giving the 'clot-buster' medication, seeing better outcomes in patients, and then hearing from patients and families who appreciate the expertise in their home-towns, Dr. Schindler said, "We have certainly reduced long-term disability in patients and improved their quality of life."

Eunice Smith definitely seconds that opinion.
It's been a long road to hope.

There's a journey each cancer patient takes that often has twists and turns, rough patches and detours and terribly unexpected bumps in the road.

Smilow Cancer Hospital has been a long time coming, but it's almost time to say, "We're ready for you and your family, ready with the facility, the technology and the care you need."

Hope is finally here.

We acknowledge with great appreciation the many generous individuals, corporations and foundations who have helped make this possible.

For information on how you can help support Smilow Cancer Hospital at Yale-New Haven, please contact YNHH's Office of Development at 203.688.9644.