Delivering remarkable cancer care

2013 cancer annual report
Based on 2012 statistics
Introduction

On behalf of Novant Health Cancer Services at Novant Health Prince William Medical Center, the cancer committee is proud to present the 2013 cancer annual report. The report offers an overview of Prince William Medical Center services available to our oncology patients.

Since 1981, Prince William Medical Center’s oncology program has been providing cancer care. Initially approved in 1986 as a Community Hospital Cancer Program by the American College of Surgeons’ Commission on Cancer (CoC), Prince William Medical Center continued our tradition in 2011 with receipt of a three-year approval with commendation in seven areas:

• Outcomes analysis
• Abstracting time frame
• Quality of NCDB data submission
• CAP guidelines
• Prevention and early detection programs
• Cancer registry staff education
• Cancer-related quality improvements

The cancer committee is extremely proud of the continuing improvements to our cancer program. As our community continues to expand and grow – so have our services.

Quality care is a team effort. The spectrum of care to our oncology patients is monitored by the cancer committee, a group of physicians and departmental representatives involved directly or indirectly in the treatment of cancer patients. The committee ensures that consultative services are available to cancer patients and their families.

Patient-oriented multidisciplinary cancer conferences are held monthly. Current case diagnosis, staging, treatment, clinical trial and management options are discussed during these conferences, affording the cancer patient with quality care. In 2013, there were 123 prospective cases and two retrospective cases discussed in a total of 12 general conferences held at Prince William Medical Center and 11 breast conferences held at Novant Health Cancer Center.

Clinical trial information is available at the hospital for patients and their families as well as staff. Patients may be enrolled in clinical trials or protocols through our staff physician offices, or by referral.

Accurate communication with our patients is important at Prince William Medical Center. Our program has made a concentrated effort to utilize the language translator line as well as on-site translators to make this possible for our multicultural community.

Thanks to all who contributed to the success of our program during the past year. Special thanks are expressed to the physicians, hospital staff and volunteers who assisted in the educational programs. It is only through the continued caring and dedication of our physicians, nurses, allied health professionals and support personnel that Prince William Medical Center will continue to provide high quality cancer care to our ever-growing community, and the most remarkable patient experience in every dimension, every time.

Alisan G. Kula, MD
Cancer committee chair
Medical director, oncology unit
Medical oncologist
Highlights of 2013

• Sponsored weekly cancer support group and monthly breast cancer support group at Prince William Medical Center
• Sponsored the fall Breast Cancer Symposium in conjunction with Ladies’ Night Out
• Sponsored the fall Prostate Cancer Symposium
• Sponsored a skin cancer screening Nov. 14, 2013 at Benedictine Sisters Monastery
• Added 3-D breast imaging to radiology
• Sponsored the “Our Mothers, Ourselves” radiology event on Mother’s Day
• Patient navigator added to staff
• Celebrated 25th anniversary of the cancer support group
• Sponsored the Prince William County Relay for Life held at Stonewall Jackson High School on June 12 and 22, 2013
• Offered cancer-related CME “Grand Rounds”
• Expanded palliative care program by adding Thomas Sullivan, MD, as director and Cynthia Coleman, RN, MA, as coordinator
• Revised treatment and follow-up letters
• Error-free National Cancer Database submission
• Psychosocial distress screening tool created
• All oncology nurses have a current Chemotherapy and Biotherapy Course Provider card from the Oncology Nursing Society
Cancer committee members

Alisan Kula, MD  
Hematology and oncology oncology unit  
medical director  
Cancer committee chair

Mark Bartolozzi, MD, FACS  
General surgery  
Cancer liaison physician  
Cancer committee co-chair

Andrew Chung, MD  
Urology

Maura Foley, MD  
Pulmonary medicine

Kenneth Henson, MD  
General surgery

Hassan Huq, MD  
Diagnostic radiology

Moria Sutton, MD  
Radiation oncology  
Community outreach coordinator

Weifen Zeng, MD  
Pathology  
Cancer conference coordinator

Kent Alford, RN  
Nursing director  
Behavioral health  
Psychosocial coordinator

Tammy Ninnemann, MLT, CTR  
Oncology data manager  
Cancer Registry  
Certified tumor registrar

Ali Avera  
Oncology data technician  
Cancer Registry

Joe Naretto, RHIA, MHA  
Director, health information management  
Cancer program administrator

Cynthia Coleman, RN, MA  
Palliative care coordinator

Dawn Cooper, PT, DPT  
Director rehabilitation services

Abra Hogarth  
Community outreach coordinator  
community relations

Rachel Ledford  
American Cancer Society;  
Account representative  
Hospital Systems  
South Atlantic Division;  
Community member;  
American Cancer Society community manager

Joanna Garvin, M.Div, MS  
Manager, chaplaincy services

Cheryl Wedel, MSW, LSW  
Case management social worker

Angela Wright, RN  
Oncology unit director  
Oncology nurse

Dori Webb, RN  
Oncology nursing unit manager

Judy LeRose  
Director, radiology

Pamela DuRousseau, MPH, RD  
Clinical nutrition manager  
Food and nutrition services
The Cancer Registry maintains the registry database of the patient’s history, diagnosis, stage, treatment and outcomes for all patients who meet state and CoC reporting requirements on cancer diagnosis or other reportable diseases (select blood disorders, benign brain and other tumors). This data generates accurate and meaningful information for cancer committee, medical staff or hospital administration use.

Our hospital services and hospital experience (registry data) are shared with the American Cancer Society through the CoC Facility Information Profile System/FIPS program. In addition, the Cancer Registry submits required cases annually to the National Cancer Data Base for national statistics and throughout the year to the Virginia Cancer Registry for statewide statistics.

Lifetime annual follow-up is conducted to obtain outcome statistics on our patients – and as an important reminder to the patients to continue to seek follow-up care.

From the reference date of Jan. 1, 2003, the Cancer Registry database contains 4,607 abstracts of cases through 2012. There are an additional 4,096 historical cases that cover 1981 through 2002. Accession year 2012 had approximately 551 new cases added.
Of the 551 cases added for patients first seen in 2012:

- 421 were analytic cases – patients were first diagnosed and/or received all or part of their first course of therapy at Prince William Medical Center and staff physician offices.
- 130 were non-analytic cases – cases that are required to be reported to the Virginia Cancer Registry: Pathology only, patients admitted for diagnosis and treatment of recurrences following completion of first course of therapy, palliative comfort care and cases discovered at autopsy.

The 2012 analytic case highlights (analytic cases only):

- Female (59%) and Male (41%)
- Caucasian/Non-Hispanic (85%)
- African-American (10%)
- Diagnosed and received all or part of their treatment at Prince William Medical Center (59%)
- Diagnosed elsewhere and received all or part of their treatment at Prince William Medical Center (15%)
- Diagnosed at Prince William Medical Center and went elsewhere for treatment (26%)
### 2012 primary site table

<table>
<thead>
<tr>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Sites</strong></td>
<td>420</td>
<td>171</td>
</tr>
<tr>
<td><strong>Oral cavity &amp; pharynx</strong></td>
<td>5</td>
<td>4</td>
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<tr>
<td><strong>Tongue</strong></td>
<td>3</td>
<td>2</td>
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<tr>
<td><strong>Salivary glands</strong></td>
<td>1</td>
<td>1</td>
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<tr>
<td><strong>Tonsil</strong></td>
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<td>1</td>
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<tr>
<td><strong>Digestive system</strong></td>
<td>66</td>
<td>34</td>
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<tr>
<td><strong>Esophagus</strong></td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td><strong>Stomach</strong></td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td><strong>Small intestine</strong></td>
<td>4</td>
<td>1</td>
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<tr>
<td><strong>Colon, excluding rectum</strong></td>
<td>29</td>
<td>16</td>
</tr>
<tr>
<td><strong>Rectum &amp; rectosigmoid</strong></td>
<td>10</td>
<td>4</td>
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<tr>
<td><strong>Anus, anal canal &amp; anorectum</strong></td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Liver &amp; intrahepatic bile duct</strong></td>
<td>6</td>
<td>5</td>
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<tr>
<td><strong>Pancreas</strong></td>
<td>5</td>
<td>3</td>
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<tr>
<td><strong>Retroperitoneum</strong></td>
<td>1</td>
<td>0</td>
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<tr>
<td><strong>Peritoneum, omentum &amp; mesentery</strong></td>
<td>2</td>
<td>0</td>
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<tr>
<td><strong>Respiratory system</strong></td>
<td>48</td>
<td>24</td>
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<tr>
<td><strong>Larynx</strong></td>
<td>3</td>
<td>3</td>
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<tr>
<td><strong>Lung &amp; bronchus</strong></td>
<td>45</td>
<td>21</td>
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<tr>
<td><strong>Bones &amp; joints</strong></td>
<td>2</td>
<td>2</td>
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<tr>
<td><strong>Soft tissue</strong></td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td><strong>Skin, excluding basal &amp; squamous</strong></td>
<td>11</td>
<td>9</td>
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<tr>
<td><strong>Melanoma - skin</strong></td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td><strong>Other, non-epithelial skin</strong></td>
<td>4</td>
<td>4</td>
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<tr>
<td><strong>Breast</strong></td>
<td>128</td>
<td>6</td>
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<tr>
<td><strong>Female genital system</strong></td>
<td>27</td>
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<tr>
<td><strong>Cervix uteri</strong></td>
<td>8</td>
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<td><strong>Corpus &amp; uterus, NOS</strong></td>
<td>12</td>
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<tr>
<td><strong>Ovary</strong></td>
<td>7</td>
<td>0</td>
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<tr>
<td><strong>Male genital system</strong></td>
<td>21</td>
<td>21</td>
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<tr>
<td><strong>Prostate</strong></td>
<td>18</td>
<td>18</td>
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<tr>
<td><strong>Testis</strong></td>
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<tr>
<td><strong>Urinary system</strong></td>
<td>42</td>
<td>30</td>
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<tr>
<td><strong>Urinary bladder</strong></td>
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<td>14</td>
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<tr>
<td><strong>Kidney &amp; renal pelvis</strong></td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td><strong>Brain &amp; other nervous system</strong></td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td><strong>Brain</strong></td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>Cranial nerves &amp; other nervous system</strong></td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Endocrine system</strong></td>
<td>7</td>
<td>3</td>
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<tr>
<td><strong>Thyroid</strong></td>
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<td>3</td>
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<tr>
<td><strong>Lymphoma</strong></td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td><strong>Hodgkin lymphoma</strong></td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Non-Hodgkin lymphoma</strong></td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td><strong>Leukemia</strong></td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>Myeloid &amp; monocytic leukemia</strong></td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
<td>35</td>
<td>20</td>
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</tbody>
</table>

### Summary by body system and sex report

**Male**
- **Oral cavity & pharynx** – 4 (2%)
- **Lung & bronchus** – 21 (12%)
- **Pancreas** – 3 (2%)
- **Kidney & renal pelvis** – 16 (9%)
- **Urinary bladder** – 14 (8%)
- **Colon & rectum** – 20 (12%)
- **Prostate** – 18 (11%)
- **Non-Hodgkin lymphoma** – 10 (6%)
- **Melanoma of the skin** – 5 (3%)
- **Leukemia** – 0 (0%)
- **All other sites** – 60 (35%)

**Female**
- **Thyroid** – 4 (2%)
- **Lung & bronchus** – 24 (10%)
- **Breast** – 122 (49%)
- **Kidney & renal pelvis** – 3 (1%)
- **Ovary** – 7 (3%)
- **Uterine corpus** – 12 (5%)
- **Colon & rectum** – 19 (8%)
- **Non-Hodgkin lymphoma** – 4 (2%)
- **Melanoma of the skin** – 2 (1%)
- **Leukemia** – 2 (1%)
- **All other sites** – 50 (20%)
Lung cancer

Alisan G. Kula, MD, Medical oncology

Lung cancer represents about 13.7 percent of all cancers in the United States, and is the second most common type of cancer in both men and women.

New cases in the United States from lung cancer (small cell and non-small cell combined) in 2013 are estimated at 228,190 cases (118,080 in men and 110,110 in women) according to the American Cancer Society.

Lung cancer is the leading cause of death from all cancers in both men and women and accounts for 27 percent of all cancer deaths. Each year, more people die of lung cancer than of colon, breast and prostate cancers combined. Estimated deaths in 2013 are 159,480 (87,260 in men and 72,220 in women). Around 1953, lung cancer became the most common cause of cancer deaths in men, and in 1985 it became the leading cause of cancer deaths in women. More women die each year from lung cancer than from breast cancer. Death rates in men have been declining since 1991, but have continued to rise in women until recently. Lung cancer mainly occurs in older people. About 2 out of 3 people diagnosed with lung cancer are 65 or older; fewer than 2 percent of all cases are found in people younger than 45. The average age at the time of diagnosis is about 70.

Overall, the chance that a man will develop lung cancer in his lifetime is about 1 in 13; for a woman, the risk is about 1 in 16. These numbers include both smokers and non-smokers. For smokers, the risk is much higher; for non-smokers, the risk is lower. Black men are about 20 percent more likely to develop lung cancer than white men. The rate is about 10 percent lower in black women than in white women. Both black and white women have lower rates than men, but the gap is closing. The lung cancer rate has been dropping among men over the past two decades and has just recently begun to drop in women.

At Prince William Medical Center between 2008 and 2012, a total of 290 lung cancers, 29 small cell and 261 non-small cell, were diagnosed and/or treated for first course of treatment as shown below.

Of the 29 small cell lung cancer patients, 55 percent were male and 45 percent were female. Of the 261 non-small cell lung cancer patients, 51 percent were male and 49 percent were female.

Lung cancer incidence by sex

*2012 data includes incomplete & suspense cases
Risk factors
Smoking, both active and secondhand is the biggest risk factor for lung cancer and accounts for 85 percent of cases. Other risk factors include occupational (asbestos exposure and inhaled products such as: coal products, arsenic, silica, cadmium, beryllium, chromium, mustard gas, chloromethyl esters, diesel exhaust or Talc) or environmental causes (radon gas, air pollution) and a family history of lung cancer.

Initial evaluation – The main issues to assess in a patient with a suspected lung cancer are the cell type – non-small cell lung cancer versus small cell lung cancer – the stage of disease and the functional status of the patient. These parameters are essential for appropriate patient management.

A tissue diagnosis is necessary to determine whether a lung cancer is a non-small cell lung cancer or a small cell lung cancer.

Staging for non-small cell lung cancer is critical in determining the appropriate treatment for a patient with resectable disease and avoiding unnecessary surgery in advanced disease.

There are several options for sampling a primary lung mass:

1. Imaging-guided percutaneous needle aspiration or biopsy
2. Endobronchial ultrasound (EBUS)-guided forceps biopsy
3. Conventional flexible bronchoscopy with forceps biopsy, blind transbronchial fine needle aspiration (TBA) or both
4. Electromagnetic navigational bronchoscopy (ENB)-guided forceps biopsy

Once a diagnosis is made, it is important to stage the cancer. Several methods are used. A PET/CAT scan can be used to see if there is evidence of spread to other organs such as the liver, bones or the adrenal glands. Alternatively, a CAT scan and bone scan can be done. An MRI of the brain is often used to evaluate the brain to see if there is evidence of metastasis. If the cancer does not appear to have spread to distant organs, a cervical mediastinoscopy or anterior mediastinotomy is also used to evaluate the mediastinal lymph nodes to determine if the cancer is resectable.

Staging at diagnosis – The system used to describe the growth and spread of NSCLC is the American Joint Committee on Cancer (AJCC) TNM staging system. The TNM system is based on three key pieces of information:

- \( T \) indicates the size of the main (primary) tumor and whether it has grown into nearby areas.
- \( N \) describes the spread of cancer to nearby (regional) lymph nodes. Lymph nodes are small, bean-shaped collections of immune system cells where cancers often spread before going to other parts of the body.
- \( M \) indicates whether the cancer has spread (metastasized) to other organs of the body. (The most common sites are the brain, bones, adrenal glands, liver, kidneys and the other lung.)

TNM staging system for lung cancer (7th edition)

Screening – Seventy-five percent of patients with lung cancer present with symptoms due to advanced local or metastatic disease that is not amenable to cure. The five-year survival rates average 16.6 percent for all individuals. Until 2011, there were no proven screening methods to detect early lung cancer that showed improvement in survival. Previously, multiple, large trials that examined both chest X-rays and/or sputum for cytology as screening tools failed to show a mortality benefit. In 2011, data was published from a large trial called the National Lung Screening Trial. This was a large, high-quality, randomized trial that screened high-risk individuals with low-dose chest CAT scans without contrast and it showed a 20 percent reduction in lung cancer mortality.
Non-small cell lung cancer

Non-small cell lung cancer is a heterogeneous group of malignancies that are often classified together because approaches to diagnosis, staging, prognosis and treatment are similar.

Prognostic groups – NSCLC can be divided into three groups to reflect both extent of disease and treatment approach.

• The best prognoses are those that are surgically resectable (generally stage I, stage II and selected stage III patients).
• Group 2 includes locally advanced lung cancer that is stage III with regional nodal disease (N2-N3). These patients have diverse natural histories and benefit from combined modality treatments.
• The final group includes patients with distant metastasis (M1) present at the time of diagnosis. These patients are not curable.

Treatment modalities

• Surgery with lobectomy; pneumonectomy; segmental, wedge or sleeve resection
• Radiation therapy, which can include conventional radiation, stereotactic radiosurgery or radiofrequency ablation
• Endoscopic photodynamic therapy for selected patients with superficial airway lesions
• Chemotherapy
• Targeted oral therapies
• Clinical trials
• Symptom-based palliative approach

Comparative evaluation - National Cancer Data Base (NCDB)

Stage at diagnosis when compared to the NCDB similar community cancer centers reveals similar percentages in all stages with a slightly higher percentage of stage I cases at PWMC and a slightly higher stage II cases with the NCDB.
Survival statistics show PWMC curves for all five stages to be slightly more favorable than those represented by the NCDB observed curves as shown below. Given that the overall survival is quite low, this is an opportunity to utilize the new screening guidelines with low-dose, computerized tomography to diagnose patients at an earlier stage and subsequently improve survival of the deadly disease.

Without treatment, small cell has the most aggressive clinical course of any type of pulmonary tumor, with a median survival from diagnosis of only two to four months according to the National Cancer Institute.

Only in very rare cases can localized treatment with surgical resection and/or radiation result in long-term survival.

The most important pre-treatment prognostic factors that consistently predict prolonged survival include good performance status, female gender and limited-stage disease according to NIH.

Careful staging and treatment planning by a multidisciplinary team of cancer specialists is required to determine the optimal treatment for patients with this disease.

Despite improvements to the best-available and most-accepted therapies, the majority of patients die of their tumors. Chemotherapy improves survival of patients with limited-stage or extensive-stage cancers, but is curative in only a minority of patients. Patient entry is highly desirable into clinical trials, such as offered by our medical oncologists.

**Small cell lung cancer**

Small cell lung cancer is a very aggressive form of lung cancer and is often disseminated, even at presentation, thus systemic chemotherapy is an integral part of the initial treatment.

Stage is the most important prognostic factor in patients with small cell lung cancer. Although the TNM staging is useful, prognosis is based on whether cancer is limited to the chest (limited stage) or spread to other organs (extensive stage). For patients with limited stage disease, median survivals range from 15 to 20 months with treatment and the five-year survival rate is 10 to 13 percent. In contrast, for patients with extensive disease, the median survival is eight to 13 months with treatment and the five-year survival is 1 to 2 percent.

**Comparative evaluation - National Cancer Data Base (NCDB)**

**Alternative staging** methods are widely utilized by physicians consisting of classifying patients as either “limited stage” (limited to thorax) or “extensive stage” (distant metastasis) as small cell lung cancer’s prognosis and treatments choices are determined in this manner.

**Staging** at diagnosis at Prince William Medical Center appears to be very similar to the NCDB with slightly more stage I cases diagnosed at Prince William Medical Center and slightly more stage III cases diagnosed with the NCDB. The majority of cases both nationwide and at Prince William Medical Center are stage IV, reflecting the very aggressive nature of this disease.
Small cell lung cancer stage at diagnosis

Treatment at Prince William Medical Center appropriately uses mostly chemotherapy and combined chemotherapy and radiation as initial treatment in the majority of cases. Limited-stage small cell lung cancer often is treated with combined chemotherapy and radiation initially. In addition, palliative radiation can be used for pain control and for treatment of cord compressions, which are sometimes the presenting symptom of both small and non-small cell lung cancers. Compared to the National Cancer Data Base, the physicians at Prince William Medical Center use similar treatment modalities, although there is a higher trend toward no treatment compared to chemotherapy alone. I believe this reflects the differences in performance status at diagnosis and the older age of the patients seen at initial diagnosis, making treatment more difficult to tolerate.

Survival statistics when compared to the NCDB show slightly lower survival trends, however survival for this cancer is quite low nationwide. This more likely reflects the small number of cases that we have – anywhere between two and eight cases a year.

Small cell lung cancer observed survival overall

References
1. PWMC: Prince William Medical Center Cancer Registry – analytic cases first seen at PWMC between 2008-2012 (unless otherwise stated). NSCLC-261 cases. SCLC-29 cases. Therapy data based on date of first diagnosis between 2008-2012 who had therapy at PWMC (unless otherwise stated). NSCLC-178 cases. SCLC-19 cases.
3. Survival Graph Stats from 2003-2006 cases: SCLC -3023 cases from 1466 Community Cancer Programs Reporting. NSCLC - 13974 cases from 1466 Community Cancer Programs Reporting. PWMC SCLC stats based on data from the PWMC Cancer Registry between 2003-2007 due to small caseload of 31 cases.
3. Surveillance, Epidemiology and End Results data base at seer.cancer.gov
Community outreach programs

Educating the community about cancer prevention and early detection is a priority at Prince William Medical Center. Our community programs feature free educational screening and early detection programs, such as prostate and breast health seminars. Prince William Medical Center serves as a cancer education resource for physicians, nurses and allied healthcare professionals, as well as for community organizations and the general public.

Cancer diagnostic services

Rigorous standards are maintained for quick and accurate diagnosis through the pathology and radiology departments. Accuracy of diagnosing and staging of cancer is maximized with laboratory tests, including sophisticated immunohistochemical studies and DNA probes through pathology. Radiological studies use the newest technology in 64-slice CT scans, PACS digital imaging, MRI and breast MRI, ultrasound, digital and 3-D mammography and the computer-aided detection (CAD) system, and PET/CT. Mammotome, stereotactic and breast MRI breast biopsies, and endoscopic procedures offered through radiology/imaging.

Cancer treatment services

Surgery and medical oncology, including chemotherapies, immunotherapies, radiofrequency ablations and prostate brachytherapy, are among the cancer treatments available.

The Novant Health Cancer Center offers both medical oncology and radiation therapy services. Radiation therapy is also referred to other fully certified facilities in the region.

Oncology unit services

Six-bed inpatient oncology unit – The nursing staff is specially trained in oncology nursing and in addressing the physical and emotional needs of cancer patients and their families. Families are encouraged to participate in the decision-making process and the care of their loved ones. Newly renovated unit, visitor sleep sofas, handicap accessible bathrooms.

Comprehensive services, including inpatient hospice services coordinated by some of our community hospice programs, are available.

Outpatient infusion center – Services provided include outpatient chemotherapy administration, transfusion services, central line management, as well as therapeutic drug administration. This area is staffed by specially trained oncology nurses.

Oncology family room – The family room offers resources, such as clinical trial, support group and diagnostic treatment information.

Case management

The Case Management Department provides care coordination and assistance with referrals.

Cancer support and education groups

The support and education groups include a weekly Tuesday night cancer support group and a monthly breast cancer support group that meets at noon. Prince William Medical Center works closely with the American Cancer Society and its various programs, including I Can Cope, Look Good Feel Better and Reach to Recovery.
**Food and nutrition services**
Registered dietitians provide customized nutrition assessments as well as counseling and education for the patient and family. Medical nutrition therapy is individualized to provide optimal nutrition support for each person.

**Information and Internet resources**
Our medical library has a wide selection of cancer literature, either on site or via the Internet, available to physicians. There is an Internet resource room near the Hylton Family Birthing Center for the convenience of patients and their families. The oncology family room also offers Internet resources.

**Pastoral services**
Supportive pastoral services are available as requested either on site or as referrals to community resources.

**Patient navigation services**
The Novant Health Cancer Center has added a patient navigator to support and help patients overcome any barriers that might prevent treatment.

**Psychosocial support services**
The psychosocial support arm of our Cancer Services team works to integrate a specialized plan into the overall treatment program that addresses the unique psychosocial concerns of the cancer patient and family. The individualized plan may include counseling, psychotherapy, health education, community resource referral and discharge planning.

**Wound/ostomy services**
A specially trained RN is available for patients requiring ostomy teaching and wound management. Certified in wound and ostomy care, she will work with your physician to develop the best plan of care as well as work closely with case management for continued support at discharge.

**Rehabilitation**
Rehabilitation services provides individualized physical and occupational therapy and speech pathology programs to maximize a person’s functional abilities. Our specialized oncology program includes:
- A 15-minute, light-touch massage program for oncology inpatients and chemotherapy patients offered three times weekly.
- An outpatient lymphedema program for individuals with cancer, lymphedema and other pre- and post-surgical conditions that result in swelling, scar tissue formation or loss of mobility.

**Volunteer services**
A group of dedicated volunteers provide help to Cancer Services and our activities.
Directory of services

Novant Health
Prince William Medical Center .................. 703-369-8000
Novant Health Cancer Center ..................... 703-753-4045
Cancer Registry ........................................ 703-369-8696
Cancer support groups:
general and breast .................................. 703-369-8543
Case management ..................................... 703-369-8363
Clinical nutrition ...................................... 703-369-8515
Novant Health
Haymarket Medical Center ...................... 571-261-3250
Home health .......................................... 703-369-8448
Laboratory ............................................. 703-369-7495
Medical library ......................................... 703-369-8475
Oncology unit .......................................... 703-369-8138
Outpatient infusion center ......................... 703-369-8840
Patient navigator at
Novant Health Cancer Center .................... 571-248-4603
Physician finder ....................................... 703-530-WELL
Prince William Surgery Center .................. 703-369-8525
Radiology ............................................... 703-369-8341
Rehabilitation services ............................ 703-369-8194
Scheduling ............................................. 703-369-8073
Novant Health Wellness Center .................. 703-369-8405

Local cancer resources
American Cancer Society – Vienna .............. 703-938-5550
American Cancer Society –
Road to Recovery .................................... 800-227-2345
Capital Caring
Palliative/Hospice – referral ....................... 1-800-869-2136
Capital Caring – Manassas branch ............... 703-392-6707
Community Hospice
of Virginia – NoVA branch ....................... 703-738-5000
Community Hospice
of Virginia – referral ............................... 866-234-7742
Evercare Hospice & Palliative Care .............. 571-262-5200
Hospice of the Rapidan ......................... 1-800-676-2012
National and website cancer resources

American Cancer Society:
Cancer.org • 800-227-2345

ASCO:
PeopleLivingWithCancer.org • 888-651-3038

Cancer Care:
CancerCare.org • 800-712-8080

Cancer Trials at NIH:
Cancer.gov/clinicaltrials

Medicine Net:
Medicinenet.com/breast_cancer/article.htm

National Cancer Institute:
Nci.nih.gov 800-4-CANCER

NCCN Patient Guidelines:
nccn.org

Patient Advocate Foundation:
PatientAdvocate.org • 800-532-5274

Novant Health Prince William Medical Center:
NovantHealth.org

Wellness Community:
TheWellnessCommunity.org • 888-793-WELL

Accreditation by:

- The Joint Commission
- The American Association of Blood Banks
- The College of American Pathologists
- American College of Surgeons Commission on Cancer
- Continuing Medical Education Program Accredited by the Medical Society of Virginia

Affiliated with:

- Northern Virginia Community College
- George Mason University Nursing Program

Licensed by:
The Virginia Department of Health

Member of:

- American Hospital Association
- Virginia Hospital and Healthcare Association
- The Northern Virginia Hospital Council
- The Healthcare Forum
Our mission
The ultimate goal of our cancer services is to reduce the morbidity and mortality of our community’s cancer patients.

Our vision
We, the employees of Prince William Medical Center and our physician partners, will deliver the most remarkable patient experience, in every dimension, every time.