

2018 Annual Report (2017 Data)

# Oncology Services



## 2018 Chairman's Report

The oncology program at Texas Health Presbyterian Hospital Dallas is committed to providing quality cancer care with a holistic approach that is centric to the overall needs of patients. The program incorporates multidisciplinary team-based care that includes nurse navigation, genetic counseling services, medical oncology, radiation oncology, physical and occupational therapy, a rehab and aftercare program, imaging services, spiritual support services, a women's health boutique, and community support and survivorship services. The program is a five-time recipient of the American College of Surgeons' Commission on Cancer Outstanding Achievement Award, the highest level of approval from the Commission on Cancer. Additionally, the breast cancer program is recognized and accredited by the National Accreditation Program for Breast Center. The lung cancer program is recognized as a Center of Excellence by the Addario Lung Cancer Foundation and Lung Cancer Alliance.

Texas Health Resources is aligned with the University of Texas Southwestern Medical Center via an integrated network, Southwestern Health Resources. This network offers expanded, coordinated care throughout North Texas for a comprehensive range of needs – from primary care to highly specialized areas such as oncology. Over the past few years, Texas Health Dallas has collaborated with UT Southwestern, a NCI designated cancer center, to find ways to work together to grow and enhance the oncology care both organizations provide. Most notably, UT Southwestern has brought their renowned genetic counseling program to our cancer center at Texas Health Dallas

The oncology program at Texas Health Dallas focuses on the importance of screening, early detection and education in the community. Throughout the year, they have continued to reach out to the community in the form of risk assessments, education about prevention and

early detection, and screening events. In 2018, to broaden these efforts, Texas Health Dallas launched a mobile mammography bus, which allows advanced breast screening technology to be delivered to patients in their own community.

The members of the multidisciplinary health care team routinely engage in case conferences and ongoing continuing education to ensure they are equipped with the latest knowledge and advances in cancer treatment. The dedication and involvement of our care providers makes the difference at Texas Health Dallas. The Cancer Committee conducts quality improvement studies each year. The data from these studies are used to identify opportunities for improvements in services, and as a result, best practices are implemented as standard of care for our oncology patients.

The Texas Health Dallas comprehensive cancer program continues to evolve to meet the needs of cancer patients in the communities we serve. We are enthusiastic about our cancer program and the comprehensive, individualized, and patient-centered oncology care we provide.

Sincerely,

**Pat Fulgham, M.D.**

*Medical Director of Surgical Oncology Services  
Chairman, Cancer Committee*



## Management of Kidney Cancer

Pat Fulgham, MD, DABU  
Director of Surgical Oncology

### Overview

The management of kidney cancer has evolved dramatically over the past ten years. Clinicians have realized that complete removal of a kidney, even for treatment of kidney cancer, places patients at an increased risk of subsequent renal failure, possible decrease in quality of life and decrease in life expectancy.

Consequently, a variety of strategies have emerged to preserve renal function. If both kidneys concomitantly are thought to provide normal renal function, then the maximum percentage of those kidneys should be preserved as long as the cancer can be completely and confidently removed. This concept, called “renal preservation”, has been made possible by more sophisticated surgical procedures allowing removal of even large tumors from the kidney while preserving functioning renal tissue. Many times, a partial nephrectomy can be performed laparoscopically and robotically, thereby shortening recovery times. For other small tumors, cryoablation (freezing of tumors) can be performed by inserting needles through the skin. This minimally invasive technique has the benefit of a low risk of bleeding and preserves as much normal kidney as possible.

### Data

For this study, we reviewed our pattern of care for Stage I-III kidney cancer and the current follow-up protocols. For 2017, a total of 53 patients underwent radical (total) nephrectomy, partial nephrectomy, or cryoablation for a variety of clinical stages (Table 1).

Table 1: Stage by Treatment

Clinical Stage	Cryoablation	Partial Nephrectomy	Radical Nephrectomy
T1a-T1b	22	13	8
T2,T2a-T2b	0	1	4
T3-T3a	0	0	5
Total	22 (42%)	14 (26%)	17 (32%)

The initial evaluation of these patients included a history and physical, laboratory studies and imaging studies (Table 2). Patients undergoing cryoablation may not routinely have a chest X-ray since the diagnosis is not always established prior to treatment. Of the 53 patients treated for presumed renal cancer, 23 (43%) underwent confirmatory needle biopsy prior to or during treatment (Table 2). 22 patients underwent cryoablation and 21 of those (95%) underwent needle biopsy. Needle biopsy is not routinely indicated when nephrectomy or partial nephrectomy is being performed as a tissue diagnosis will be rendered with the removal of the tumor. Cryoablation destroys the tumor so needle biopsy is useful in establishing a diagnosis.

Table 2: Clinical Workup

Work-up	Number	Percent
H&P	53	100%
Lab	45	85%
Abdominal CT or MRI	49	92%
Chest x-ray	25	47%
Needle biopsy	23	43%

The suggested follow-up of patients after treatment for renal cancer varies widely in the medical literature. The intensity of follow up depends in part on tumor type and size. Common follow up strategies include laboratory studies and some form of imaging during the

first 6 to 12 months after treatment. Review of our patient follow up data shows that a high percentage of patients undergo imaging within 6 to 12 months (Table 3). The percentage of patients undergoing imaging within one year likely underestimates the true percentage owing to distribution of follow-up care among providers and the fact that many patients are directed to free-standing imaging centers, decentralizing that information. The reporting of follow up is complicated by conflicting recommendations from various professional organizations and societies and the fact that many patients are followed by primary physicians, surgical specialists, interventional radiologists and medical oncologists.

Table 3: Follow-Up Imaging

Follow-Up Imaging (6-12 mo)	Percent
Cryoablation	83%
Partial nephrectomy	67%
Radical nephrectomy	71%

The most recent data available from the American College of Surgeons National Cancer Database is from 2015 and shows radical nephrectomy 44.77%, partial nephrectomy 30.14% and local tumor destruction 6.73%. The distribution of treatment modalities at our institution (cryoablation 42%, partial nephrectomy 26%, and radical nephrectomy 32%) is consistent with national figures for radical nephrectomy and partial nephrectomy. This higher percentage of local tumor destruction (cryoablation) at our institution reflects the evolving movement toward minimally invasive treatments (Table 4).

Table 4: Treatment Comparison

Treatment	National*	Texas Health Dallas
Radical nephrectomy	45%	32%
Partial nephrectomy	30%	26%
Cryoablation	7%	42%
Other	18%	0%

### Summary

Based on our review of this information, one area of improvement is obtaining documentation of the recommended follow-up diagnostic testing. As aforementioned, the ability to accurately capture this data is confounded by patients referred from outside institutions where this testing may have been completed but not documented within the Texas Health Dallas electronic medical record system. Therefore, our data likely underestimates the true percentages of patients who receive the recommended follow-up. Programs to improve communication between referring institutions and independent physician practices with the cancer registry would allow for more complete data collection and accurate representation of follow up.