Combining Support and Comfort with the Best of Care.
Dear Colleague:

As Shady Grove Adventist Hospital celebrates its 25th Anniversary this year, we can look back and see the tremendous strides and growth that have taken place in the hospital and also in our Cancer Program. New advances in surgery and the addition of services here such as radio-iodine therapy for thyroid cancer and prostate seed implantation show how our oncology services continue to expand and grow to meet the needs of our community.

We are pleased to present our 2004 report.

Dr. Joseph Haggerty was appointed our new Cancer Liaison Physician in 2004. His role will be to develop and strengthen relationships with community cancer care agencies and spearhead initiatives to comply with Cancer Program Standards in collaboration with other cancer program team members.

The Cancer Committee, in cooperation with the Pathology Department at Shady Grove, has implemented College of American Pathologists (CAP) protocols. These protocols allow pathologists to effectively deliver information necessary to provide quality patient care. Mandated by the American College of Surgeons Commission on Cancer (ACoS CoC) in 2004, our Pathology Department began implementation of various cancer sites throughout 2003. Having maintained our ACoS CoC Program accreditation since 1998, we look forward to recertification in 2005.

The Colorectal Cancer Screening Program, supported by the Cigarette Restitution Fund, continues to provide education, outreach and free screenings to eligible men and women residing in Montgomery County. Adventist HealthCare’s Breast Cancer Screening Program for low-income and uninsured women continues to be the largest in the county, funded in large part by grants from the Komen Foundation and Avon.

As we head into 2005, pending regulatory approval, we look forward to continued hospital expansion with the proposed additions of a four-story patient tower and a new Ambulatory Surgery Center. With more space to grow, we hope to continue to expand our oncology services here at Shady Grove.

Sincerely,

Jerome Sandler, M.D.
Chairman
General Surgery

Gregory Dick, M.D.
Co-Chairman
Plastic & Reconstructive Surgery

Joel Barton, M.D.
Pathology
Cancer Conference Coordinator

Bruce Bortnick, M.D.
Radiology

Donald Bridges, M.D. & Marlana Ottinger, M.D.
Radiation Oncology

Cary Brown, M.D.
General Surgery

Ethel Finn
Social Work

Michael Franklin
Vice President

Nancy Gambill, R.N.
Director, 2-West
Quality Improvement Coordinator

Mary Haddad, R.N.
Quality Improvement

Joseph Haggerty, M.D.
Hematology/Oncology
Cancer Liaison Physician
Community Outreach Coordinator

Elham Hekmat
Pharmacy

Stuart Hough, M.D.
Pain Management

Judy Lichty & Candace Moran
Prevention & Wellness
Breast Cancer Screening Program

Linda Love, CTR
Cancer Registry
Data Quality Coordinator

Nancy Markus, M.D.
General Surgery

Chitra Rajagopal, M.D.
Hematology/Oncology

Christopher Sinha, M.D.
Otolaryngology

Vijay Varma, M.D.
Nuclear Medicine

Robert Varney, M.D.
General Surgery

Mary Ann Yancey, R.N.
Oncology Clinical Nurse Specialist

Shady Grove Adventist Hospital
This is your hospital
First-ever “Ovarian Cancer Awareness Walk” a Success!

The first-ever Dorothy Leora Holmes 3K Walk for Ovarian Cancer Awareness was held on Sunday, October 17, in Hagerstown, Md.

More than 100 participants lent their time and support to this year’s walk, which was organized by Janet Fountain at Potomac Ridge Behavioral Health Center with the assistance of Shelia Myers at Shady Grove Adventist Hospital. Janet currently serves as president of the Western Maryland Division of the National Ovarian Cancer Coalition.

The walk raised $4,500, more than double the original fund-raising goal. The proceeds will benefit the National Ovarian Cancer Coalition and the American Cancer Society.

Thank you to the Adventist HealthCare Support Center, Potomac Ridge Behavioral Health Center and Shady Grove Adventist Hospital for providing in-kind donations and items for the favor bags for the walk. For more information regarding the National Ovarian Cancer Coalition Western Maryland Division, please call 301-797-6091.

During the year, Shady Grove Adventist Hospital:

- Maintained three-year accreditation—the maximum award from the Commission on Cancer of the American College of Surgeons.
- Conducted 500 screenings for bladder, colorectal, skin, oral and prostate cancers during our annual Cancer Screening Day.
- Hosted a regional CME program on the latest breast cancer treatment advances.
- Served 17 women through our Look Good Feel Better program.
- Participated in the American Cancer Society’s Relay for Life and the Komen Foundation’s Race for the Cure.
- Supported our Patient Advisory Group in the creation of a H.O.P.E. Butterfly Quilt with patients and families. (See page 8 for more.)
Prostate Seed Implantation Comes to Shady Grove

Prostate cancer is currently the second most common cancer diagnosed in American men (following skin cancer) and the second leading cause of cancer death of American men. During their lifetime, approximately one in six American men will develop prostate cancer.

There is plenty of room for optimism, however. When caught early, prostate cancer is one of the most curable forms of cancer. And fortunately, with the advent of a simple blood test known as Prostate Specific Antigen (PSA), most prostate cancers can be diagnosed in the earliest stages when cure rates are extremely high.

There's also a minimally invasive treatment for prostate cancer patients, which became available at Shady Grove Adventist Hospital in September 2004. Prostate Seed Implantation, or PSI, is now offered as a treatment option for prostate cancer patients by Shady Grove Adventist Hospital’s urologists and the radiation oncologists at Maryland Regional Cancer Care.

Prostate Seed Implantation is much as it sounds. Tiny radioactive seeds are injected into the prostate gland. According to Dr. Donald Bridges, the radiation oncologist involved in the start-up of PSI at Shady Grove, the one-time procedure is minimally invasive. It takes approximately one hour to complete, and can be performed as a same-day outpatient procedure.

Patients who undergo the procedure in the morning are usually discharged to go home in the late morning or early afternoon, and may return to work and to other activities within 24 to 48 hours. PSI is also a nearly painless procedure. While patients are sent home with pain medications, most recipients never need to use them.

At Shady Grove Adventist Hospital, the team of physicians who conduct this procedure has significant experience in Prostate Seed Implantation, having already performed over 500 PSI procedures at other institutions. For more information about PSI treatment, contact Dr. Donald Bridges at the Maryland Regional Cancer Care, at 301-309-6765.

PSI is a minimally invasive procedure in which tiny radioactive “seeds”, compared here to the size of a dime, are placed in the prostate gland.

Spotlight on Maryland Regional Cancer Care

Last year, Adventist HealthCare and Holy Cross Hospital partnered to form Maryland Regional Cancer Care (MRCC) with the goal of providing high-quality radiation oncology services to the communities of Montgomery and Prince George's counties and parts of the District of Columbia.

With six full-time radiation oncologists, this radiation oncology program is the largest single radiation subspecialty group in the greater Washington metropolitan area. Five state-of-the-art community-based facilities comprise the core operating centers owned by MRCC, with about 150 patients per day receiving radiation therapy in these five locations.
Included in the treatments offered through MRCC is Intensity Modulated Radiation Therapy (IMRT), a state-of-the-art cancer treatment method that delivers high doses of radiation directly to cancer cells in a targeted way, which is much more precise than conventional radiotherapy. IMRT can deliver higher radiation doses directly to cancer cells while sparing the surrounding healthy tissue.

IMRT can also be used to treat tumors that might have been considered untreatable in the past due to close proximity of vital organs. Treating such tumors requires tremendous accuracy. In the case of prostate cancer, exposure of the nearby bladder or rectum can be minimized.

Additional breakthrough therapies offered by MRCC include mammosite and Photodynamic Therapy (PDT). Mammosite is a new minimally invasive method of delivering internal radiation therapy following a lumpectomy for breast cancer. Therapy is given on an outpatient basis, and mammosite typically takes only four to five days instead of the traditional methods that take six weeks. Therapy is focused on the area of the breast where the tumor originated. Mammosite is appropriate for early stage candidates.

With PDT, a photosensitizing agent is injected into the bloodstream and absorbed by cells all over the body. The agent remains in cancer cells for a longer time than it does in normal cells. When treated cancer cells are then exposed to laser light, the photosensitizing agent absorbs the light and produces an active form of oxygen that destroys the treated cancer cells.

In addition, MRCC’s affiliate Position Emission Tomography (PET) is a unique imaging device that visualizes metabolic activity in the body. Metabolic and functional abnormalities can reveal disease states before structural damage is evident. The most common applications of PET in cancer patients are for staging the extent of the disease, detecting recurrent disease early, and for monitoring the response to therapy. PET has also been shown to have value in diagnosing cardiac diseases and various brain disorders.
Focusing on Lung Cancer

The American Cancer Society reports an estimated 173,770 new cases and 160,440 deaths from lung cancer (small cell and non-small cell combined) in the United States in 2004.

There are two main types of lung cancer: non-small cell lung cancer (NSCLC) and small cell lung cancer (SCLC). Each affects different types of cells in the lung and grows and spreads in different ways. Seventy-five to 80% of people diagnosed with lung cancer have non-small cell lung cancer, making it the most common type of lung cancer. Fifteen to 20% of people diagnosed with lung cancer in the United States have small cell lung cancer.

While smoking is recognized as the number one cause of lung cancer, the Environmental Protection Agency estimates that every year 3,000 people in the United States die of lung cancer caused by second-hand smoke. Approximately 14% of newly diagnosed lung cancer cases at Shady Grove from 1999 to 2003 were patients who had never smoked.

At diagnosis, patients with NSCLC can be divided into three groups that reflect the extent of disease and treatment approach.

The first group of patients has tumors that are surgically resectable (generally stages I and II). When compared with NCDB data, Shady Grove patients with stage I disease demonstrated a 53% 5-year survival compared to a 40% 5-year survival nationally. Unfavorable survival comparison with national data on stage II patients can be attributed to small sample size (6 cases). Even patients with operable disease can have prognosis adversely influenced by the presence of pulmonary symptoms, vascular invasion, large tumor size (>3 cm), or presence of the positive hilar lymph nodes.

Clinical trials looking at adjuvant chemotherapy and chemoprevention trials for this subgroup of patients are currently ongoing. At the most recent American Society of Clinical Oncology annual meeting, results from a CALGB trial showed adjuvant chemotherapy significantly reduces all-cause and lung cancer mortality in stage IB NSCLC.

This is the first randomized trial to demonstrate significantly improved survival for a carboplatin-based adjuvant chemotherapy regimen in a uniform population with NSCLC.

Patients with resectable disease who have medical contraindications to surgery can be considered for curative radiation therapy, with or without chemotherapy.

The second group includes patients with either locally (T3T4) or regionally (N2N3) advanced lung cancer. Selected patients may undergo neoadjuvant chemotherapy and radiation therapy in order reduce tumor size and possibly make them candidates for later surgical resection.

The final group of patients has distant metastases (M1) found at the time of diagnosis. At Shady Grove, 37% of our NSCLC patients (1999 to 2003) fell into this category. This group can be treated with radiation therapy or chemotherapy for palliation of symptoms. Patients with good performance status, women, and patients with distant metastases confined to a single site appear to live longer than others. All newly diagnosed patients with NSCLC are potential candidates for studies evaluating new forms of treatment.
Small Cell Lung Cancer (SCLC)

Without treatment, small cell carcinoma of the lung has the most aggressive clinical course of any type of lung cancer, with median survival from diagnosis of only 2 to 4 months. Compared with other cell types of lung cancer, small cell carcinoma has a greater tendency to be widely disseminated by the time of diagnosis, but is much more responsive to chemotherapy and radiation. Patients are grouped by extent of disease; limited stage (limited to chest cavity or supraclavicular lymph nodes) or extensive stage (spread outside chest cavity).

Examining cases from 1999-2003 (total 46 new cases) at Shady Grove, 65% of patients with SCLC had extensive stage or M1 disease, compared with 70% nationally. This figure remains the same from the last SCLC study done in 1999. Slightly over half (53%) are female.

According to the NCI, for patients with limited-stage disease, a median survival of 16 to 24 months with current forms of treatment can reasonably be expected. For patients with extensive stage disease, a median survival of 6 to 12 months is reported with currently available therapy, though long-term survival is rare. Shady Grove patients with extensive disease (stage IV) diagnosed between 1999-2002 had a one-year survival rate of 36%, with the two-year survival rate dropping to 8%. The pretreatment prognostic factors that consistently predict for prolonged survival include good performance status, female gender, and limited-stage disease. Patients with involvement of the central nervous system or liver at the time of diagnosis have a significantly worse outcome.

Radiation therapy plays an extremely important role in palliation of symptoms of the primary tumor and of metastatic disease, particularly brain, epidural, and bone metastases. PCI or prophylactic cranial radiation may be administered in limited stage patients in complete remission to attempt to forestall or prevent brain metastases.

All patients with this type of cancer may appropriately be considered for inclusion in clinical trials at the time of diagnosis.

### SGAH New Lung Cancer Cases by Stage 1999-2003

<table>
<thead>
<tr>
<th></th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
<th>Unk Stage</th>
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<tbody>
<tr>
<td>Non-Small Cell</td>
<td>55</td>
<td>16</td>
<td>87</td>
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<td>10</td>
<td>7</td>
<td>268</td>
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<tr>
<td>Small Cell</td>
<td>3</td>
<td>1</td>
<td>8</td>
<td>30</td>
<td>4</td>
<td>0</td>
<td>46</td>
</tr>
<tr>
<td>TOTAL</td>
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<td>17</td>
<td>95</td>
<td>123</td>
<td>14</td>
<td>7</td>
<td>314</td>
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### 5-Year Survival Non-Small Cell Lung Cancer Cases Diagnosed 1995-1996 SGAH vs. NCDB

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<tr>
<th></th>
<th>One Year</th>
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<tr>
<td></td>
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<td>NCDB</td>
<td>SGAH</td>
<td>NCDB</td>
<td>SGAH</td>
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<tr>
<td>STAGE 1</td>
<td>82%</td>
<td>78%</td>
<td>73%</td>
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<tr>
<td>STAGE 2</td>
<td>66%</td>
<td>68%</td>
<td>45%</td>
<td>45%</td>
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<tr>
<td>STAGE 3</td>
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<td>21%</td>
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<tr>
<td>STAGE 4</td>
<td>21%</td>
<td>18%</td>
<td>7%</td>
<td>6%</td>
<td>4%</td>
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</table>

Unknown & stage 0 cases excluded
SGAH Data N= 67
NCDB Data reported from 1,707 hospitals, total cases 178,504.
Reporting on the 2004 Cancer Registry

The Cancer Registry plays a significant role in the Cancer Program at Shady Grove. The Registry collects, manages and analyzes data on patients with cancer and certain precancerous conditions. Data are maintained on all cancer patients diagnosed and/or treated at Shady Grove since January 1, 1995, currently over 7,000 patients. During 2003, 745 analytic or “new” cases were accessioned into the Registry.

As an American College of Surgeons Commission on Cancer-approved cancer program, Shady Grove Adventist Hospital participates in contributing data to the National Cancer Data Base. The NCDB is a nationwide, facility-based oncology data set that currently captures 75% of all newly diagnosed cancer cases in the United States annually, and holds information on over 15 million cases of reported cancer diagnoses for the period 1985 through 2002, and continues to grow. Data collected include patient characteristics, tumor staging and histology characteristics, type of first course treatment administered, disease recurrence, and survival information. Comparing our data with other hospitals in the U.S. allows us to benchmark our quality of care in order to provide excellence in service to our cancer patients.

Shady Grove also participates in the National Cancer Information Center Project, sponsored by the American Cancer Society. On a local level, Registry data is reported to the Maryland Cancer Registry as mandated by state law. In all circumstances, confidentiality of patient-identifying information is strictly maintained. Only aggregated data are analyzed and published; the individual cancer patient is never identified outside of the Registry system.

Accurate and meaningful data are ensured through extensive quality control checks performed by the Cancer Committee and the registrar. The Cancer Committee reviews 10% of analytic abstracts for quality and accuracy on an annual basis. 2003 cases demonstrated a 91% AJCC staging rate exceeding the Commission on Cancer requirement. Annual follow-up of patients is another function of the Cancer Registry. More than 3,000 cases are currently under active follow-up, with compliance greater than the 90% standard. In 2003, the Registry processed 37 requests for data in addition to the publication of the Cancer Program’s annual report.

The Cancer Registry is also responsible for coordinating Tumor Board, a weekly multidisciplinary conference that reviews state-of-the-art information on the diagnosis and treatment of cancer patients and applies this information to the treatment of specific patients. In 2003, a total of 106 case presentations were made. All were prospective, well exceeding the Commission on Cancer requirements. Attendees receive category I CME credit. Tumor Board is held every Tuesday morning at 7:30 a.m. at Shady Grove Adventist Hospital.
## Shady Grove Adventist Hospital
### 2003 Primary Site Distribution Table

<table>
<thead>
<tr>
<th>Primary Sites</th>
<th>Total Number of Cases</th>
<th>Class of Case</th>
<th>Sex</th>
<th>Stage Distribution</th>
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<tr>
<td></td>
<td>Analytic</td>
<td>Non-Analytic</td>
<td>Male</td>
<td>Female</td>
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<tr>
<td><strong>ALL SITES</strong></td>
<td>832</td>
<td>745</td>
<td>87</td>
<td>320</td>
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<tr>
<td><strong>HEAD AND NECK</strong></td>
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<td>19</td>
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<td>11</td>
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<tr>
<td>Tongue</td>
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<tr>
<td>Salivary Glands</td>
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<tr>
<td>Mouth</td>
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<td>Tonsil</td>
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<td>Pharynx (Naso/Oro/Hypo)</td>
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<tr>
<td>Stomach</td>
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<td>Small Intestine</td>
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<td>Rectum &amp; Rectosigmoid Junction</td>
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<td>16</td>
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<tr>
<td>Anus</td>
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<td>Other Biliary (Includes Intrahepatic Bile Duct)</td>
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<td>2</td>
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<td>Pancreas</td>
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<tr>
<td>Liver</td>
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<td>6</td>
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<td>5</td>
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<tr>
<td><strong>LUNG</strong></td>
<td>93</td>
<td>85</td>
<td>8</td>
<td>38</td>
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<tr>
<td>Small Cell</td>
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<td>3</td>
</tr>
<tr>
<td>Non-Small Cell</td>
<td>71</td>
<td>66</td>
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<tr>
<td>Other Lung</td>
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<tr>
<td><strong>SOFT TISSUE</strong></td>
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<td>Melanoma</td>
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<td>Other Skin</td>
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<td><strong>BREAST</strong></td>
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<td>Cervix (includes CIN-3)</td>
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<tr>
<td>Uterus</td>
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<td>Ovary (includes primary peritoneal)</td>
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<td>Other Female Genital</td>
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<td><strong>MALE GENITAL</strong></td>
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<td>Prostate</td>
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<td><strong>TESTIS</strong></td>
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<td>Bladder</td>
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<td>Kidney &amp; Renal Pelvis</td>
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<td>Ureter</td>
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<td><strong>ENDOCRINE</strong></td>
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<td><strong>MULTIPLE MYELOMA</strong></td>
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<td><strong>LEUKEMIAS</strong></td>
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<td>10</td>
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<tr>
<td><strong>BRAIN &amp; CNS</strong></td>
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<td>7</td>
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<tr>
<td>Miscellaneous and Unknown Primary</td>
<td>31</td>
<td>27</td>
<td>4</td>
<td>17</td>
</tr>
</tbody>
</table>

*UNK - Stage Unknown
**N/A - NO AJCC staging system for site/histology
Cancer Care Physicians Honored with RISES Award

T he RISES Award was created by Shady Grove Adventist Hospital to recognize those physicians who live and work in a manner that reflects the five values of our hospital: Respect, Integrity, Service, Excellence and Stewardship.

These five values tie into our Culture of Caring, a hospital initiative that promotes the values and attributes that we seek to live by as we interact with each other, our patients, business partners and physicians.

We are proud to recognize four of our cancer care physicians, Dr. Jerome Sandler, Dr. Joseph Haggerty, Dr. James Brown and Dr. Nancy Markus, who have all received the RISES Award.

Jerome Sandler, M.D. was the first recipient of the Culture of Caring Physician RISES Award. Dr. Sandler, Cancer Committee Chairman for the past 10 years, has been performing general surgery at Shady Grove Adventist Hospital for 23 years and is highly regarded by his colleagues, our employees and his patients. His nomination came with the support of 75 members of our health care team.

Dr. Joseph Haggerty, Cancer Liaison Physician, and Dr. James Brown, both oncology physicians at Shady Grove, were recognized after the hospital received a handwritten letter from a hospital employee, who was also a patient, shortly before she lost her fight with cancer. Her spirit lives on as we honor these physicians — for their medical talents and heart-felt care they provide.

The PACU staff nominated Dr. Nancy Markus, also a Cancer Committee member, for consistently demonstrating genuine care and compassion for her patients and their families. The patients and staff find her very personable and kind.

Shady Grove thanks these physicians for their commitment and devotion to our hospital and their patients.

Patient Advisory Group Creates H.O.P.E. Butterfly Quilt

T his year, the Patient Advisory Group joined together with cancer patients, their family members and caregivers to create the H.O.P.E. (Healing Oncology Patients Everywhere) Butterfly quilt. The project was supported by a generous grant from the Society for the Arts in Healthcare/Johnson & Johnson and the Culture of Caring/Shady Grove Adventist Hospital.

The H.O.P.E. Butterfly quilt features a golden mandala design incorporating a cancer ribbon motif in various appropriate colors. Colorful pieced butterflies flutter in an airy background around the mandala. Panels featuring the appliquéd initials H.O.P.E. and the names of those who worked on the project flank the central panel. The modular design allowed many people to contribute a section by working independently.

A team of skilled volunteers supervised by a professional quilt maker will assemble the component pieces and finish the quilt. Ultimately it will hang in the Oncology unit where it will be a welcome and beautiful addition, as well as a reminder to all of the communal experience enjoyed and shared in its creation.
OUR MISSION

is to deliver excellent health care through a ministry of physical, mental and spiritual healing.
Important Numbers

Shady Grove Adventist Hospital

Main Number..................301-279-6000
Admitting........................301-279-6007
Breast Cancer Support Group...301-279-6604
Cancer Registry..................301-279-6245
Community Education............800-542-5096
Emergency Department.........301-279-6053
Employment Center...............301-279-6135
Foundation Office...............301-279-6570
Oncology Unit....................301-279-6306
Volunteer Services..............301-279-6111

Community Services

Health Ministries.................301-315-3136
Interfaith Counseling...........301-869-8428

Shady Grove Adventist Hospital
This is your hospital.

9901 Medical Center Drive
Rockville, MD 20850

www.ShadyGroveAdventistHospital.com