



**Sacred Heart Hospital**

*James H. Baroco Cancer Center*

A close-up photograph of a person's arm, likely a healthcare worker, wearing a white glove. A pink awareness ribbon is pinned to the arm. The background is a soft-focus image of a stethoscope.

**Cancer Report**  
**2003**

# Cancer Committee *2003*

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# Chairman's Report 2003



**Dr. Joanne Bujnoski,  
DO, Radiation Oncology  
Chairman**

The cancer program at Sacred Heart Hospital (SHH) has served our community for many years and has been accredited by the American College of Surgeons

(ACoS), Commission on Cancer (CoC) since 1986. As chairman of the cancer committee, I am responsible for reviewing our program on an annual basis. My report will summarize and highlight goals and accomplishments from our 2003 program.

Last years annual report (2002) was published on the SHH web site for the first time permitting wider access and opportunity for our patients to explore and evaluate our services. Our Cancer Committee feels it is important to share cancer registry data and program services with patients, medical staff, administration and the community on-line.

The Cancer Committee continues to encourage research protocol participation. Our research staff reports accrual to trials at bimonthly committee meetings. We presented a conference detailing our cancer research activities/efforts to senior hospital administration as well as the board of directors in 2003.

In 2003, we had our most successful prostate cancer screening event. The focus of screening, as in past years, was to reach the African-American population who are at greater risk of developing prostate cancer. For nearly 15 years, SHH has offered annual prostate cancer screenings with only marginal success in recruiting African-Americans. In 2003, a total of 83 men were screened with 84% of this group representing African-Americans. Strategic use of the local media (television and radio) was used to promote

awareness and encourage participation weeks before the screening event.

We continue to make progress in engaging managing physicians in the AJCC staging process as mandated by the ACoS, CoC which is a requirement for accreditation. The clinical and surgical staging system is based upon the premise that cancers of the same anatomic site and histology have similar patterns of growth and response to therapeutic endeavors including prognoses.

Although there is no panacea cure for cancer, improvements in cancer treatment and outcomes are being made. The risk of having or dying from cancer continues to decline according to the American Cancer Society and the National Cancer Institute. The Center for Disease Control reports that cancer patients diagnosed between 1995-2000 have an estimated 64% survival rate. The percentage of patients who have survived more than five years after being diagnosed with cancer has increased over the past two decades. It is tremendously gratifying to see patients in clinic, who I treated over 10 years ago at SHH and are still disease free.

In review of our cancer registry data, a total of 1,312 new cases were accessioned in 2003 with 1,078 analytical cases and 234 non-analytical cases. Our annual report this year will feature an article on Cutaneous Melanoma including survival data submitted by our Cancer Liaison Surgeon, Dr. Michael Caluda.

I want to thank the Cancer Committee members, allied health care workers, and administration for their continued interest and support of our oncology patients in providing the highest quality cancer care here, at home in Pensacola. Next year, as SHH oncology care workers we will continue to focus on education, early detection, treatment, follow up management and end of life care issues.

# Cutaneous Melanoma



**Dr. Michael J. Caluda, III  
MD  
Cancer Liaison Physician**

Melanoma is regarded as the most lethal form of skin cancer. While accounting for only 4% of skin cancer cases, it is responsible for nearly 80% of all skin cancer deaths. Overall the number of new cases of this disease continues to be on the rise. Estimates for 2004 from the American Cancer Society show that nationwide approximately 55,100 new cases will be diagnosed and 7,910 patients will die of melanoma. Current estimated lifetime risk of developing melanoma is 1 in 55 for men and 1 in 82 for women.

Early recognition is important, as melanoma is a highly curable disease in its localized stages. Most patients are aware that ultraviolet radiation (sunlight and tanning beds) is the main modifiable risk factor in the development of this disease. Educational and screening programs wisely emphasize limiting sunlight exposure and utilizing high SPF (sun protection factor > 15) sunscreens for prevention. Melanoma often occurs in apparently normal areas of skin, on the palms and soles, and even in nail beds. Development on mucosal surfaces, intraocular areas, and other sites is fortunately less common. As melanoma can often appear or develop in common skin nevi, these bear special attention. Signs of potential cancer include **A** – Asymmetry, **B** – Border irregularity, **C** – change in coloration, **D** – Diameter > ¼ inch or change in size and shape of a nevus. Darker or variable coloration, size increase, and pruritis are potential early signs. New non-pigmented skin lesions should be suspected also, as up to 10% of melanomas are amelanotic. As disease progresses other signs such as bleeding, ulceration, and satellite nodules may appear.

Biopsy is indicated for all suspected skin lesions, and ideally should be a full thickness local excision. Shave biopsies should not be performed, since pathologic characterization is based primarily on tumor thickness and depth of invasion. The vertical measurement of tumor thickness in millimeters by optical micrometry (Breslow classification) is regarded as the most accurate and reproducible for microstaging. Clark's classification, a measurement of the anatomic level of tumor invasion into and through the dermis, is also useful in determining prognosis for some lesions. The histopathologic subtypes of cutaneous melanoma are well described, but have not been shown to have any real use in determining prognosis or overall outcome. They include Nodular, Superficial Spreading, Lentigo Maligna, and Acral Lentiginous (palms, soles, and subungual).

Staging for cutaneous melanoma has been defined by the American Joint Committee on Cancer (AJCC) with TNM classification. These definitions and clinical stages are included on Tables 1 – 2. The primary prognostic factors of tumor thickness and regional lymph node involvement are well demonstrated, with lymph node involvement and the presence of distant metastatic disease being most important to overall survival. Other negative prognostic factors such as tumor ulceration, Clark's level of invasion, and number of involved lymph nodes are also included. Patients with localized disease (Stage 0, I, or II) are usually thought to have potentially curable lesions. Most cases fortunately present in these early stages. Historical data from the United States Surveillance, Epidemiology, and End Results (SEER) studies show approximately 86% of cases presenting as localized disease, with 9% diagnosed as regional, and 4% found with distant metastasis present.

Surgical treatment is indicated in nearly every new case of melanoma. Local control at the primary site requires wide full thickness excision, with the extent

# Cutaneous Melanoma

**Table 1: American Joint Committee on Cancer (AJCC) staging for Melanoma of the Skin**

**Primary Tumor (T)**

TX	Primary tumor cannot be assessed (e.g., shave biopsy or regressed melanoma)
T0	No evidence of primary tumor
Tis	Melanoma <i>in situ</i>
T1	Melanoma ≤ 1.0mm in thickness with or without ulceration
T1a	Melanoma ≤ 1.0mm in thickness and level II or III, no ulceration
T1b	Melanoma ≤ 1.0mm in thickness and level IV or V or with ulceration
T2	Melanoma 1.01-2mm in thickness with or without ulceration
T2a	Melanoma 1.01-2.0mm in thickness, no ulceration
T2b	Melanoma 1.01-2.0mm in thickness, with ulceration
T3	Melanoma 2.01-4mm in thickness with or without ulceration
T3a	Melanoma 2.01-4.0mm in thickness, no ulceration
T3b	Melanoma 2.01-4.0mm in thickness, with ulceration
T4	Melanoma greater than 4.0 mm in thickness with or without ulceration
T4a	Melanoma > 4.0mm in thickness, no ulceration
T4b	Melanoma > 4.0mm in thickness, with ulceration

**Regional Lymph Nodes (N)**

NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastasis
N1	Metastasis in one lymph node
N2	Metastasis in two or three regional nodes or intralymphatic regional metastasis without nodal metastases
N3	Metastasis in four or more regional nodes, or matted metastatic nodes, or in-transit Metastasis or satellite(s) with metastasis in regional node(s)

**Distant Metastasis (M)**

MX	Distant metastasis cannot be assessed
M0	No distant metastasis
M1	Distant metastasis

of margins (0.5 to ≥ 2cm) depending on the nature of tumor advancement at the site. Elective regional lymph node dissection has essentially been replaced by lymphatic mapping and sentinel lymph node biopsy (SLNB), a minimally invasive technique. The combination of wide excision and SLNB for staging is ideal for intermediate thickness (1.0 to 4mm) lesions, as a positive sentinel node result can be followed by regional lymph node dissection with potentially curative intent. Survival benefit has not been shown for SLNB in lesions < 1 mm thick, as the historic rate of metastasis for these tumors is quite low (≤ 3%). Survival benefit also has not been shown for SLNB in thick lesions > 4 mm. In such cases therapeutic removal of regional nodes may be indicated to provide local control for a clinically positive (palpable) basin.

SLNB is performed by injection of a radionuclide tracer and visual (blue) dye into the region of the primary melanoma, followed by mapping with traditional lymphoscintigraphic techniques to determine the overall target location and to detect any in-transit potential metastases. Surgery is then performed immediately following to include wide excision of the primary site and excision of the sentinel node(s) using an intraoperative gamma probe device for identification. The combination of blue dye and radionuclide tracing has been shown to have a high (>95%) accuracy rate in detecting the sentinel node. Several studies have validated SLNB as an effective screening tool for detecting nodal metastasis, and have shown significantly decreased morbidity as compared to full elective regional node dissection.

Adjuvant therapy for the treatment of melanoma continues to be an area of considerable study, since truly effective regimens for non-localized disease have yet to be demonstrated. Immunotherapy with high dose interferon alpha (IFN-α) and interleukin-2 (IL-2) is most often used for patients with nodal and distant metastatic disease, and demonstrates some

# Cutaneous Melanoma

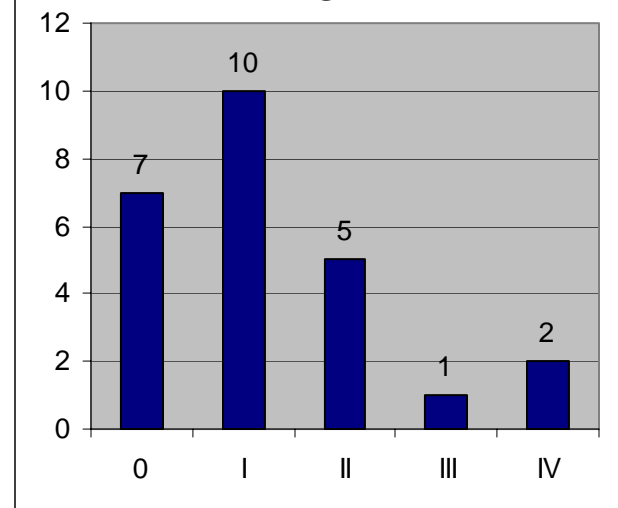
clinical response but no clear survival benefit. Treatment with these cytokine agents is unfortunately very uncomfortable and difficult for many patients to endure. Traditional chemotherapy can be used in the metastatic setting also, with reported response rates up to 50% for some combination regimens. Again, no clear survival benefit demonstrated. Other treatments include investigations into melanoma vaccines and isolated limb chemoperfusion, available in a clinical trial setting. Radiation therapy has effective use in the palliative treatment of metastatic lesions such as CNS, bone, and viscera; particularly those sites relatively inaccessible to surgical removal.

**Table 2: American Joint Committee on Cancer (AJCC) TNM Clinical Stage Grouping for Melanoma of Skin**

<b>Stage 0</b>	Tis	N0	M0
<b>Stage IA</b>	T1a	N0	M0
<b>Stage IB</b>	T1b	N0	M0
	T2a	N0	M0
<b>Stage IIA</b>	T2b	N0	M0
	T3a	N0	M0
<b>Stage IIB</b>	T3b	N0	M0
	T4a	N0	M0
<b>Stage IIC</b>	T4b	N0	M0
<b>Stage III</b>	Any T	N1	M0
	Any T	N2	M0
	Any T	N3	M0
<b>Stage IV</b>	Any T	Any N	M0

**Our experience:** For calendar year 2003 we treated 25 analytic cases of cutaneous melanoma at Sacred Heart, with Stage distribution as noted in Table 3. All patients underwent appropriate primary site excision (wide excision for all invasive tumors). SLNB was performed in 9 cases, with only one patient (Elderly man, Stage IIC lesion with clinically negative node basin) refusing any surgical node staging. Two patients underwent full regional node dissection, one after a positive SLNB. One Stage IIA patient elected

**Table 3: 2003 SHH Melanoma By AJCC Stage at Initial Diagnosis**



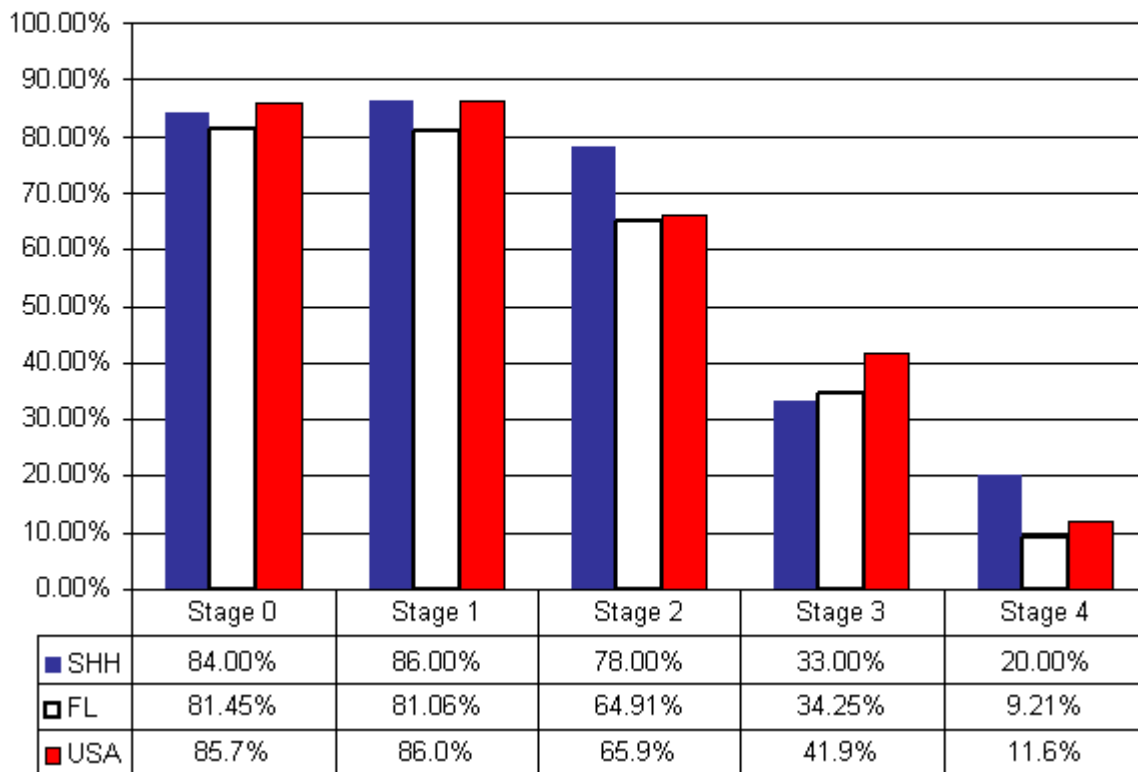
to receive immunotherapy with Interferon. Of the three patients with metastatic disease, one (Stage IIIC) elected to enroll in a phase III randomized trial utilizing immunotherapy at an outside facility. Of our two Stage IV patients, one received radiation and the other received chemotherapy and hormonal therapy. Retrospective review of our center's five-year survival data shows excellent correlation with both statewide and national data (Table 4).

Overall our patients at Sacred Heart receive access to the highest level of care for treatment of cutaneous melanoma. Surgical care for this disease includes appropriate local and staging procedures, including the current standard in minimally invasive techniques to reduce morbidity and improve outcomes. Standard adjuvant therapy is provided at our center, with access to clinical vaccine and other trials available through coordination with our medical oncologists. We hope to continue to provide the highest level of melanoma and cancer care to our community for many years to come.

# Cutaneous Melanoma

**Table 4: Malignant Melanoma Observed 5-Year Survival Rates**  
**Sacred Heart Hospital - Florida\* - USA\***  
**AJCC TNM 4th Edition Staging System**

\*NATIONAL CANCER DATA BASE PATIENTS DIAGNOSED IN 1995 & 1996



# Cancer Registry

Wendy Williams  
RHIT, CTR



Julie Manley  
RHIT, CTR

The Cancer Registry is a vital component of the Community Hospital Comprehensive Cancer Program at Sacred Heart Hospital. The registry receives and maintains data on patients diagnosed and/or receiving treatment for cancer at our facility. This data is used to monitor cancer incidence and cancer care management. It also serves as a source for tracking outcome and survival statistics of patients through annual follow-up on all analytic cases.

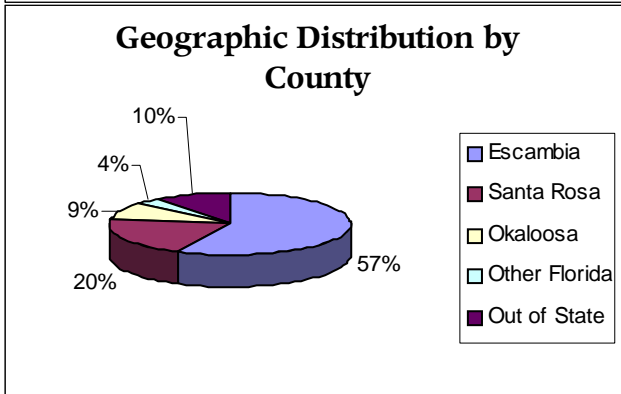
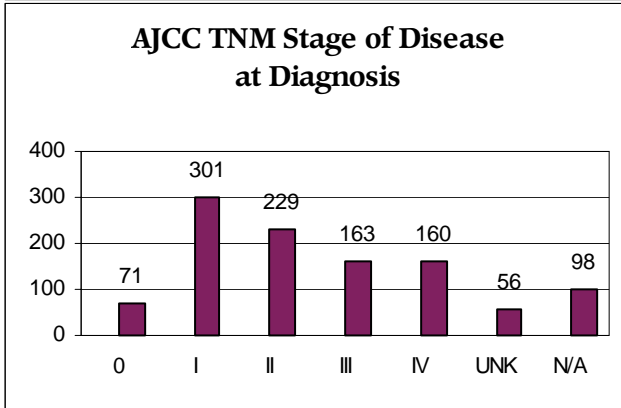
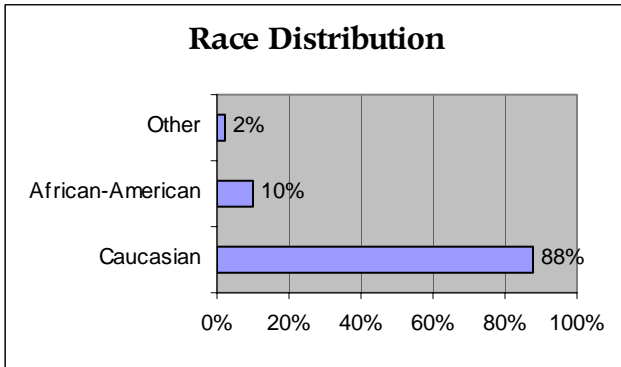
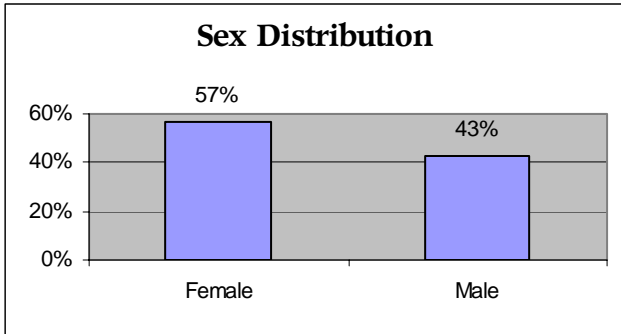
In 2003, the Cancer Registry accessioned 1,312 new cases into the database, bringing the total number of cases to over 16,780. This reflects data collected since the reference date of January 1, 1979. As required by state law, cases are submitted to the Florida Cancer Data System (FCDS).

The Cancer Registry currently conducts annual follow-up on over 5,400 patients, and has a current follow-up rate of 90% percent for all patients.

A total of 164 cases were presented at the weekly multidisciplinary Tumor Board meetings during the past year. All cases presented were prospective which included current patient management issues. The average physician attendance at Tumor Board was 13. The Gynecology Pathology Conference meets several times each month. Gynecology pathology is discussed, whether benign or malignant, with a total of 95 cases were presented in 2003. Also, pediatric tumor board meets monthly.

Continuing education is a necessity for the rapidly changing requirements in cancer data collection and utilization of data. Julie Manley, RHIT, CTR attended the Florida Cancer Registrars Association and Florida Cancer Data System combined annual conference in Clearwater, Florida, in July/August 2003.

# Cancer Statistics and Data 2003



### Statistical Summary of Registry Data

A total of 1312 cases were accessioned into the database at Sacred Heart Hospital in 2003. Analytical cases 1,078 (those patients initially diagnosed and/or received initial treatment) accounted for 82% of total population. Non-analytical cases 234 (those patients not initially diagnosed or initially treated at SHH) accounted for 18%. Nationally, 1,334,100 new cancer cases were projected to be diagnosed in 2003, with 96,100 from Florida.

The data shows distribution by race: 88% White, 10% Black, and 2% Other. A total of 57% were female and 43% male. Geographically, 57% of analytic cases were from Escambia County, 20% from Santa Rosa County, 9% from Okaloosa County, 4% from other Florida counties and 10% of cases reported were out of state. Stage distribution for analytic cases was 8% stage 0, 28% stage I, 21% stage II, 15% stage III, 15% stage IV, 13% were unknown stage or not applicable. Cancer incidence by site demonstrated that the ten most frequent sites are breast 19%, lung 15%, prostate 9%, colorectal 9%, bladder 4%, uterus 4%, leukemia 4%, non-Hodgkin's lymphoma 3%, kidney/renal pelvis 3%, and thyroid 3%.

### Ten Most Frequent Sites

	SHH	National
Breast	19%	16%
Lung	15%	13%
Prostate	9%	17%
Colorectal	9%	11%
Bladder	4%	4%
Uterus	4%	3%
Leukemia	4%	2%
Non-Hodgkin's Lymphoma	3%	4%
Kidney & Renal Pelvis	3%	2%
Thyroid	3%	2%

# Primary Site Tabulation

PRIMARY SITES	TOTAL	CLASS A	N/A	SEX M	F
<b>ALL SITES</b>	<b>1312</b>	<b>1078</b>	<b>234</b>	<b>567</b>	<b>745</b>
<b>ORAL CAVITY</b>	<b>31</b>	<b>27</b>	<b>4</b>	<b>19</b>	<b>12</b>
LIP	1	1	0	1	0
TONGUE	8	8	0	5	3
OROPHARYNX	1	1	0	1	0
HYPOPHARYNX	0	0	0	0	0
OTHER	21	17	4	12	9
<b>DIGESTIVE SYSTEM</b>	<b>199</b>	<b>167</b>	<b>32</b>	<b>102</b>	<b>97</b>
ESOPHAGUS	7	5	2	6	1
STOMACH	13	11	2	5	8
COLON	91	75	16	45	46
RECTUM	22	18	4	13	9
ANUS	5	5	0	2	3
LIVER	6	4	2	3	3
PANCREAS	37	33	4	20	17
OTHER	18	16	2	8	10
<b>RESPIRATORY SYSTEM 203</b>	<b>178</b>	<b>25</b>	<b>123</b>	<b>80</b>	
NASAL/SINUS	0	0	0	0	0
LARYNX	21	18	3	17	4
LUNG/BRONCHUS	180	158	22	104	76
OTHER	2	2	0	2	0
<b>BLOOD &amp; BONE MARROW</b>	<b>55</b>	<b>37</b>	<b>18</b>	<b>29</b>	<b>26</b>
LEUKEMIA	35	24	11	19	16
MULTIPLE MYELOMA	14	11	3	4	10
OTHER	6	2	4	5	0
<b>BONE</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>0</b>
<b>CONNECT/ SOFT TISSUE 9</b>	<b>8</b>	<b>1</b>	<b>6</b>	<b>3</b>	
<b>SKIN</b>	<b>41</b>	<b>30</b>	<b>11</b>	<b>24</b>	<b>17</b>
MELANOMA	35	25	10	20	15
OTHER	6	5	1	4	2
<b>BREAST</b>	<b>242</b>	<b>207</b>	<b>35</b>	<b>5</b>	<b>237</b>
<b>FEMALE GENITAL</b>	<b>140</b>	<b>118</b>	<b>22</b>	<b>0</b>	<b>140</b>
CERVIX UTERI	28	24	4	0	28
CORPUS UTERI	47	43	4	0	47
OVARY	36	26	10	0	36
VULVA	21	18	3	0	21
OTHER	8	7	1	0	8
<b>MALE GENITAL</b>	<b>148</b>	<b>108</b>	<b>40</b>	<b>148</b>	<b>0</b>
PROSTATE	135	97	38	135	0
TESTIS	9	7	2	9	0
OTHER	4	4	0	4	0
<b>URINARY SYSTEM</b>	<b>97</b>	<b>84</b>	<b>13</b>	<b>57</b>	<b>40</b>
BLADDER	58	46	12	38	20
KIDNEY / RENAL	36	35	1	17	19
OTHER	3	3	0	2	1
<b>BRAIN &amp; CNS</b>	<b>20</b>	<b>14</b>	<b>6</b>	<b>9</b>	<b>11</b>
BRAIN	20	14	6	9	11
OTHER	0	0	0	0	0
<b>ENDOCRINE</b>	<b>43</b>	<b>33</b>	<b>10</b>	<b>8</b>	<b>35</b>
THYROID	41	32	9	7	34
OTHER	2	1	1	1	1
<b>LYMPHATIC SYSTEM</b>	<b>50</b>	<b>35</b>	<b>15</b>	<b>23</b>	<b>27</b>
HODGKIN'S DISEASE	11	5	6	6	5
NON-HODGKIN'S	39	30	9	17	22
<b>UNKNOWN PRIMARY</b>	<b>23</b>	<b>23</b>	<b>0</b>	<b>9</b>	<b>14</b>
<b>OTHER/ILL-DEFINED</b>	<b>10</b>	<b>8</b>	<b>2</b>	<b>4</b>	<b>6</b>

# Community Outreach Programs

**BLAB TV Presentation** on Colorectal Cancer – March 25

**Camp Bluebird** – April/October

**Skin Cancer Seminar** – April 24

**Relay for Life** – May 9-10

**Prostate Cancer Screening** – June 10

**I Can Cope** – June/July

**Drive for the Cure** – August 8

**Making Strides Against Breast Cancer 5K Walk** – November 1

**Through with Chew** – An educational forum for middle school age children presented by registered nurses. Included question and answer sessions and role play.

**Cancer Support Group** open to all adult cancer patients. Meets 3rd Tuesday of every month

**Breast Cancer Support Group** open to all women with diagnosis of breast cancer. Met 3<sup>rd</sup> Wednesday of every month.

# Multidisciplinary Services

## Treatment of Children with Cancer

Nemours Children's Clinic, an affiliate of Sacred Heart Children's Hospital, has been a Children's Oncology Group (COG) institution through the Community Clinical Oncology Program since 1983. Each year, Nemours Children's Clinic places newly diagnosed patients and relapsed cancer patients on available COG studies.



## St. Catherine Oncology Unit

Our multidisciplinary team approach addresses every facet of the patient's needs, from the time of hospital admission to the time of discharge and into the home setting. The provision of all private rooms in our 38-bed oncology unit offers a family centered approach to our mission of service to those who are poor in mind, body or spirit. In close liaison with the physician, the registered nurse sets the wheels in motion to involve numerous ancillary services in an effort to ensure complete, individualized care.

## Cancer Research

Patients in Northwest Florida and South Alabama are given the opportunities to remain in Pensacola and participate in some of the latest NCI sponsored

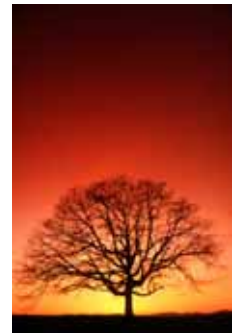
Cooperative Group or pharmaceutical sponsored trials. Northwest Florida's only GYN oncologists, in partnership with Moffitt Cancer Center in Tampa, are able to offer eligible women entry into Gynecologic Oncology Group (GOG) treatment trials. Our medical



oncologists, in partnership with Tulane University Cancer Center in New Orleans, offer eligible patients opportunities to participate in other "treatment/medical research" trials covering a variety of different cancers and offer eligible community members participation in cancer "prevention" trials. In 2003, the total number accrued to clinical trials exceeded the minimal American College of Surgeons, Commission on Cancer standard.

## Palliative Care

Palliative care is the comprehensive management of patients' physical, psychological, social spiritual and existential needs. It can be part of the treatment plan for any person and their family at any stage of disease. Palliative care affirms life and regards the dying process as a natural process that is a profoundly personal



experience of the individual and family. The focus of palliative care is the relief of suffering, control of symptoms, quality of life as determined the patient, and maintenance of functional capacity. Palliative care guides patients and families as they journey through the changing goals of care and assists the patient who wishes to address issues of life completion and closure. For more information about palliative care call Erin Bowers, RN, Palliative Care Manager at (850) 416-7705 or Randal Hamilton, RN (850) 416-2693.

## Pastoral Care

The Pastoral Care department provides spiritual care for all patients, families, and hospital staff. A chaplain regularly visits the patients on the St. Catherine's oncology unit, and in the outpatient Center for Cancer Care. The priest chaplain is always available to patients and families. Besides being available to

# Multidisciplinary Services

patients during their hospital stay or visit, we extend our support even after discharge to their homes or nursing homes.

## Social Services

Social workers provide assistance in facilitating communication between health care team members and patients and their families. Social workers are professionals trained to provide counseling and support as well as assistance in identifying resources that are helpful when coping with a serious illness. This may include providing information about government entitlement programs, home health care, durable medical equipment, hospice, transportation, vocational rehabilitation, short term and long term disability and alternative living arrangements. Individual, family and group counseling are available at no charge.

## Nutrition Services

Nutrition support is essential for the patient to withstand the stress of cancer and its treatment. All cancer patients are screened for nutritional risks and may be referred to a registered dietician or registered diet technician.



During one-on-one counseling, the patients are able to discuss with the dietician or diet technician their current diet, nutritional problems and a personalized care plan is developed. When needed, tube feeding and intravenous nutrition therapies are available.

## Performance Improvement

The Cancer Service Line includes a multidisciplinary team approach to performance improvement. By identifying short and long-term improvement opportunities and applying outcome criteria, we are able to

ensure that the performance improvement is ongoing and pertinent. Performance improvement activities initiated in 2003 included monitoring the number of terminally ill cancer patients receiving blood or blood product transfusion in the last 28 days of life and advance directive identification and documentation for every oncology patient.

## Miracle Camp

Miracle Camp has a mission to provide a premier camp and retreat center for chronically and/or terminally ill children and adults. Miracle Camp has a special commitment to cancer patients regardless of financial barriers or physical concerns the ultimate goal is to meet the physical, spiritual, and emotional needs of every client. Miracle Camp is set in a



pristine, wooded, 40-acre nature preserve. A large pond provides fishing and canoeing, while a beautiful labyrinth and a serene outdoor chapel serve as quiet havens for introspection, reflection, and inspiration. As evidence of the amazing opportunities that Miracle Camp offers, Camp Bluebird, a biannual adult cancer camp, now hosts all of its camps here. At Miracle Camp we are proud to say, "Everybody deserves a moment in the sun."

# Directory

**Sacred Heart Hospital** 416-7000

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**Sacred Heart Home Care** 470-9288

**Pastoral Care** 416-7928  
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**Nutritional Services** 416-7579  
Edith Baker, RD

**Outpatient IV Therapy** 416-6704  
Jackie Olney, RN, Manager

**Smoking Cessation** 416-7764  
Lisa Masterson, RRT

# Our Core Values

*We Are Called To:*

*SERVICE OF THE POOR*

Generosity of spirit, especially for persons  
most in need

*REVERENCE*

Respect and compassion for the dignity and diversity  
of life

*INTEGRITY*

Inspiring trust through personal leadership

*WISDOM*

Integrating excellence and stewardship

*CREATIVITY*

Courageous innovation

*DEDICATION*

Affirming the hope and joy of our ministry



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